DR. MATTHEW SKANCKE

PATIENT REGISTRATION FORM (update every 3yrs)

DATE:_____ REFERRED BY:_____

PATIENT NAME:_____AGE:_____DATE OF BIRTH:_____

ADDRESS:_____
STREET APT CITY STATE ZIP

HOME PHONE :(___) _____ WORK PHONE:(____)_____CELL PHONE:_____

PRIMARY CARE DOCTOR
_____ADDRESS:_____PHONE# _____

SOCIAL SECURITY #_____YOUR EMPLOYER:_____

PATIENT EMAIL: _____

EMERGENCY CONTACT: _____PHONE:(___)_____RELATIONSHIP:_____

May we discuss your care with this person? _____Yes _____No

DO YOU HAVE A LATEX ALLERGY? Yes No **DO YOU HAVE A HISTORY OF MRSA? Yes No**

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:_____

POLICY/MEMBER ID#:_____GROUP#:_____

SUBSCRIBER:_____SUBSCRIBER DOB:_____ SUBSCRIBER SS#_____

RELATIONSHIP/SUBSCRIBER: _____ SUBSCRIBER EMPLOYER:_____

SECONDARY INSURANCE

NAME:_____PHONE:(___)_____

POLICY#:_____GROUP#:_____

SUBSCRIBER:_____SUBSCRIBER DOB:_____ SUBSCRIBER SS#_____

RELATIONSHIP/SUBSCRIBER:_____ SUBSCRIBER EMPLOYER:_____

I HEREBY AUTHORIZE & DIRECT MY INSURER TO ISSUE PAYMENT CHECK(S) FOR BENEFITS DUE ME FOR SERVICES BY DR. MATTHEW SKANCKE. I FURTHER AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM. REGARDLESS OF MY INSURANCE BENEFITS, IF ANY, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE FEES FOR THE SERVICES RENDERED.

I AM AWARE THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLE, CO-PAYMENT AND BALANCE REMAINING AFTER INSURANCE PAYMENT.

THE INSURANCE INFORMATION THAT I HAVE PROVIDED IS CORRECT, AND I AM AWARE THAT I MUST NOTIFY DR. SKANCKE OF ANY CHANGES AT THE TIME OF MY VISIT. IF I FAIL TO DO SO I AM AWARE THAT DR. SKANCKE WILL BILL ME FOR ANY REMAINING BALANCES.

_____ _____
SIGNATURE OF PATIENT/AUTHORIZED PERSON DATE

We must have a copy of your insurance cards back and front

PATIENT MEDICAL HISTORY

PATIENT NAME:_____ DATE:_____

REASON FOR TODAY'S VISIT:_____

PAST SURGERIES:_____

_____

PAST ENDOSCOPIES, PLEASE LIST TYPE AND DATE :_____

OTHER ILLNESSES_____

_____

MEDICATIONS VITAMINS & DOSES_____

_____

_____

_____

ALLERGIES:_____

HEIGHT_____ WEIGHT_____ BLOOD PRESSURE_____

****

DO YOU CURRENTLY HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS?

Yes No DIZZINESS, CONVULSIONS OR SEIZURES, NUMBNESS OR TINGLING, STROKE
Yes No GLAUCOMA

Yes No ASTHMA, COPD, PNEUMONIA, TUBERCULOSIS, PULMONARY EMBOLUS, SHORTNESS OF BREATH, WHEEZING

Yes No CHEST PAIN,PALPITATIONS OR FLUTTERING HEART, HIGH BLOOD PRESSURE, SWELLING OF THE FEET, ANKLES OR HANDS, MITRAL VALVE PROLAPSE, HEART ATTACK, BYPASS OR STENT, VALVE SURGERY

Yes No DIABETES, THYROID DISEASE

Yes No URINARY PROBLEMS, BLOOD IN URINE, KIDNEY STONES, GROIN BULGE

Yes No VARICOSE VEINS, ARTERY PROBLEMS

Yes No CANCER type:_____

Yes No HEPATITIS, PANCREATITIS, ULCER

Yes No BLEEDING PROBLEMS, EASY BRUISING, BLEEDING GUMS, ANEMIA, PAST TRANSFUSION

Yes No DO YOU TAKE ASPIRIN OR ANTI-INFLAMMATORIES (MOTRIN, ALEVE, ETC.) WHICH ONE? _____
HOW OFTEN? _____

Yes No **DO YOU TAKE PLAVIX OR OTHER BLOOD THINNERS / PLATELET INHIBITORS**

Yes No DO YOU TAKE ANY DIET MEDICATIONS

Yes No DO YOU SMOKE? HOW LONG_____ PACKS PER DAY_____

Yes No DO YOU USE ALCOHOL DRINKS/DAY_____ WEEK_____ MONTH_____

Reviewed by Physician_____ **Date:**_____

ACKNOWLEDGEMENT OF SURGERY CANCELLATION / RESCHEDULING POLICY

In the event you need surgery and choose to have the surgery, this is an acknowledgement that you are aware of our policy. Cancelling and rescheduling procedures is costly to our practice. Therefore, please choose your procedure dates **CAREFULLY.** If you need to cancel or reschedule your surgery, the following policies apply:

1. If you do not give **14 DAYS NOTICE** of your cancellation or reschedule, **YOU WILL BE CHARGED A FEE OF 10% OF THE COST OF YOUR PROCEDURE.**

2. Your procedure will be rescheduled, however it could take up to 30 days before a new surgery date is available.

3. **BEFORE** your procedure is rescheduled, you **MUST PAY** the above mentioned fee.

Signature **X**_____ Date_____

CANCELLATION/ NO SHOW OFFICE APPOINTMENTS ACKNOWLEGEMENT AGREEMENT

In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in an urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another patient the possibility to have access to timely medical care. Late cancellations will be considered as a "no-show". Exceptions will only be made in extraordinary circumstances. Cancellations made more than 24 hours in advance of your scheduled appointment time will not be assessed a cancellation fee of $30.00

Signature **X**_____ Date_____

HIPAA RELEASE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires written authorization to be obtained before a healthcare provider or staff may release your health information to a third party, even if that third party is a family member or other individual closely associated with you. This means that all information, whether medical, financial, or circumstantial, may not be released to or discussed with anyone, including your spouse, unless previously authorized by you in writing. Please complete the following HIPAA Release Form. You are not required to answer affirmatively to any of the following questions, but we do ask that you indicate an answer, either affirmative or negative, to assist us in complying with HIPAA.

May the doctor or his staff release your medical or financial information to relatives or friends, and if so, to whom? Please list the name(s) and relationship:_____

May the doctor or his staff leave a message on your home answering machine? Y/N With someone at home? If so with whom?

_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

A full copy of our privacy practices is available at the reception desk. If I would like to receive a copy, one will be provided to me. I acknowledge that a copy of the privacy practices is available and I have been given an opportunity to review it in its entirety.

Printed Name_____ Date of Birth_____

Signature **X**_____ Date_____

IN - OFFICE CONSENT FORM

Dear Patient:

Dr. Skancke requests that you read and sign the following consent form.

Dr. Skancke will review and discuss your history with you. If necessary, he will perform a physical examination to determine the cause of your complaint and advise you on the possible remedies.

The physical examination may include a visual examination of the anus, and /or a digital rectal exam. An internal exam of the rectum requires visualization through an anoscope (anoscopy) or proctoscope (proctosigmoidoscopy). A proctosigmoidoscopy is generally performed to determine the source of anal, rectal or colonic bleeding. The proctosigmoidoscopy may not determine the source of the bleeding and carries an approximate 1 in 1,000 risk of perforation of the colon. An abnormality found at the time of proctosigmoidoscopy may be biopsied in the office. Biopsies carry an additional risk of bleeding and perforation. Other procedures which may be performed in the office include the removal of thrombosed hemorrhoids, drainage of a rectal abscess and treatment of perianal lesions. These surgical procedures carry a small risk of postoperative bleeding, infection and reaction to the local anesthesia.

Before any therapeutic procedure is performed the doctor will thoroughly discuss with you your options and obtain your verbal consent prior to performing the procedure.

If you have any questions about this consent form or the procedures outlined, please feel free to discuss them with your doctor at the time of your consultation.

I have read the above and consent to examination and treatment by Dr. Skancke.

_____ _____

Patient Signature **Date**

_____ _____

Witness **Date**

_____ _____

Physician Signature **Date**

****Medicaid patients ONLY agreement: I understand that my doctor is not in network with Medicaid and that I will be responsible for my balance either at the time of my visit OR once my primary insurance has processed my claim****

_____

Patient Signature

Bowel Symptom Questionnaire

Doctor's Name: _____

Name: _____ Date of Birth: _____

Phone number: _____ Date: _____

Please circle to indicate on average how often you experience the following:

	Never (0 times)	**Rarely** (less than once a month)	**Sometimes** (less than once a week)	**Usually** (less than once a day)	**Always** (Everyday)
1. **Solid Stool Leakage**	0	1	2	3	4
2. **Liquid Stool Leakage**	0	1	2	3	4
3. **Gas Leakage**	0	1	2	3	4
4. **Wears Pads (for stool)**	0	1	2	3	4
5. **Lifestyle Alteration**	0	1	2	3	4

TOTAL FOR QUESTIONS 1 - 5 ABOVE	

Minimum Score 0 (perfect continence), Maximum Score 20 (complete incontinence)

6. Would you be interested in learning about a long-lasting option that may help you with your symptoms? ☐ **YES** ☐ **NO**

Please consult your physician on how to use this document. This questionnaire is provided as a sample of a document that can be used to track your symptoms. Completing the questionnaire can be helpful to your healthcare provider because it describes your daily habits and your symptoms. Your doctor will use this information to help determine a treatment for your condition.

CONFIDENTIAL