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:_____

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 (or attach list)
_____
_____
_____
_____

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:**_____

SURGERY CANCELLATION / RESCHEDULING POLICY ACKNOWLEDGEMENT

Cancelling and rescheduling procedures is costly to our practice. Please choose your procedure dates **CAREFULLY.** If you need to cancel or reschedule your surgery the following policies apply:

1. Your procedure will be rescheduled, however it may be 30 days before a new surgery date is available.

2. If you do not give **14 DAYS NOTICE** of your cancellation or reschedule, **YOU WILL BE CHARGED A FEE: $75 FOR COLONOSCOPIES, $150 FOR ANAL RECTAL SURGERIES, AND $350 FOR MAJOR SURGERIES.**

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

Personal & Family Cancer History

Name: _____ Date of Birth: _____ Date: _____

Please answer the below questions and include male and female blood relatives, on both your mother and father's side. Please estimate ages of diagnosis to the best of your ability. Include the following relatives:

Parents, Siblings, Children, Grandparents, Aunts/Uncles, Nieces/Nephews

Have YOU ever been diagnosed with the following:			**Which Cancer:**	**Age of Diagnosis**
Colon or Uterine cancer at age 64 or under	Yes	No	_____	_____
Breast, ovarian, prostate, or pancreatic cancer at any age	Yes	No	_____	_____

Have your RELATIVES ever been diagnosed with the following:			**Which Relative(s):**	**Age of Diagnosis**
Breast cancer at age 49 or younger	Yes	No	_____	_____
Ovarian cancer at any age	Yes	No	_____	_____
Breast cancer in both breasts (bilateral) at any age	Yes	No	_____	_____
3 breast cancers on the same side of the family at any age	Yes	No	_____	_____
Male breast cancer at any age	Yes	No	_____	_____
A parent, sibling, or child with pancreatic cancer at any age	Yes	No	_____	_____
Jewish ancestry with one or more breast cancer in the family	Yes	No	_____	_____

Have you or any close blood relatives ever had testing for genes that cause cancer? Yes No

If yes, please explain: _____

_____

If you answered "YES" to any of the above questions, please complete this section:

As part of our services, we offer cancer risk assessment to our patients based on personal and family history, at no additional charge. If you answered **"yes"** to any of the above questions, **we recommend that you talk with your provider about understanding your genetic risk**. Please check an option below, sign your name, and hand this to the office staff when your name is called.

_____ **Yes**, I would like to complete this step today.

_____ **No**, I decline the opportunity to learn about my genetic risk today.

Patient Signature: _____ **Today's Date**: _____