Advanced Hemorrhoid Specialists
sensitive care for a sensitive condition™

PATIENT REGISTRATION

Chart #: _____

PATIENT INFORMATION

Please provide driver's license for us to copy.

☐ Male ☐ Female ☐ Single ☐ Married - Spouse's Name: _____
☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Name: _____
Last First Middle Prefer to be called (if different)

Address: _____
Street City/State Zip

Phone: (Home) _____ (Work) _____ (Cell) _____

Birthdate: _____ Age: _____ Social Security #: _____ Email: _____

What is your preferred method of contact for appointment reminders? (please circle) Home/Work/Cell phone Text message Email

Employer: _____ Occupation: _____

Employer Phone: _____ Employer City: _____

Primary Care (Family) Physician: _____ Physician Phone: _____

Physician Address: _____
Street City/State Zip

How did you hear about us? (please mark all that apply)

☐ Mimi Vanderhaven Newspaper ☐ Internet Search ☐ Patient Referral _____
☐ TV – (Channel? _____) ☐ Facebook ☐ Physician Referral _____
☐ Radio – (Station? _____) ☐ Sign ☐ Other _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

Name: _____ ☐ Male ☐ Female
Last First Middle

Address: _____
Street City/State Zip

Phone: (H) _____ (W) _____ (Cell) _____

Birthdate: _____ Social Security #: _____ Relationship: _____

Employer: _____ Phone: _____ City: _____

INSURANCE INFORMATION

Please provide insurance cards for us to copy.

PRIMARY

Insurance Company: _____
Subscriber Name: _____
Relationship: _____ Birthdate: _____
Subscriber ID #: _____
Group Name: _____
Group #: _____ Effective: _____

SECONDARY

Insurance Company: _____
Subscriber Name: _____
Relationship: _____ Birthdate: _____
Subscriber ID #: _____
Group Name: _____
Group #: _____ Effective: _____

Notify in Case of Emergency EMERGENCY

Name: _____ Relationship: _____ Phone: _____
Last First

Signature: _____ *Date:* _____

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HEALTH HISTORY

Name: _____ Chart #: _____

MEDICAL HISTORY

Please check any of the following which you have or have had:

☐ Heart Attack/Angina	☐ Asthma/Emphysema	☐ Skin Disease*	☐ Alcoholism
☐ Other Heart Disease*	☐ Tuberculosis	☐ Anemia	☐ Hepatitis B, or C
☐ High Blood Pressure	☐ Other Lung Disease*	☐ Bleed or Bruise Easily	☐ Other Liver Disease*
☐ High Cholesterol	☐ Alzheimer's Disease	☐ Impaired Immune System	☐ Heartburn/Ulcers
☐ Diabetes	☐ Stroke	☐ HIV	☐ Crohn's Disease
☐ Thyroid Disease	☐ Seizures	☐ Venereal Disease	☐ Ulcerative Colitis
☐ Kidney Disease*	☐ Other Neurological Disease*	☐ Chronic Back Pain	☐ Diverticulosis
☐ Cancer*	☐ Psychiatric Condition*	☐ Arthritis	☐ Anal Fissure/Fistula

*please elaborate:_____

Other medical conditions: _____

MEDICATIONS

Please list any medications or vitamins taken regularly:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you take any blood thinners? _____

Please list any allergies that you have (including latex): _____

SURGICAL HISTORY

Please list any surgeries that you have had (include dates):

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

	Age, if living	Health problems	If deceased, age and cause of death
Father			
Mother			
Siblings			
Children			

Any family members with colon cancer or polyps in the colon? ☐ Yes ☐ No Who/Age? _____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No ☐ Quit_____ Packs per day _____ Years _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit_____ Number of drinks per week _____

Do you use recreational drugs? ☐ Yes ☐ No ☐ Quit_____ Type _____

Are you pregnant? ☐ Yes ☐ No ☐ Don't know

Signature: _____ *Date:* _____