West County Colon & Rectal Care
Robert M. West, D.O.
(314) 720-0050

Please print

Last Name:_____________________________ First Name:_______________________ MI:_______

Address:____
City: ________________________________State: _______________Zip Code:__________________

Home Phone # (_____)_____________ Work # (_____)______________Cell # (____)___________

Birthdate:____/____/_____ SSN:________-______-_________

Marital Status (circle): Single Married Divorced Widowed Sex (circle): Male Female

Preferred # for appointment reminders (circle): Home Work Cell

Email address (optional):________________________________Occupation:___________________

Emergency Contact:_____________________________ Phone #:_____________________________

Primary Care Physician:___________________________Phone:______________Fax:_____________

Did they refer you? Yes No If no, please tell us who referred you or how did you hear about us:____Phone:______________Fax:___________

Do you want your notes from this office sent to your primary/referring physician? Yes No

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Primary Insurance:___________________________ ID#:________________Group #:_____________

Name of Insured:_________________________Relationship:_____________Birthdate:___________

Secondary Insurance:_________________________ ID#:________________ Group #:____________

Name of Insured:_________________________Relationship:_____________Birthdate:___________

____ _________________________
Patient Signature Date

____ _________________________
Legal guardian signature if other than patient Date

15510 Olive Blvd. Ste 115
Chesterfield, MO 63017

23 North Oaks Plaza Ste 274
St. Louis, MO 63121

(314) 720-0050
(314) 787-2132 –fax
www.drrobertmwest.com

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What brings you in today: ____
____
When did these symptoms start? ____
If you are having rectal bleeding, how often does it occur, is it spontaneous or with a bowel movement? ____
____
If you are in pain, please rate your pain from a 1-10 (10 being the worst):__________________
____

Medications (including blood thinners and over the counter medications/vitamins):
____
____
____
List any **allergies** to medications, food or latex: _______________________________________
____

Medical History

Date: Results:

Colonoscopy:____
Barium Enema:______________________________________
Family history of colon cancer: Yes No
If yes, at what age were they diagnosed and which relative?_____________________________
Family history of colon polyps: Yes No
If yes, at what age were they diagnosed, which relative and what type of polyp (if known)?
____

List any surgeries or hospitalizations you have had (include any pacemaker or any metal implants):
____
____
Please tell us any other medical history that we should be aware of (are you HIV positive, have Hepatitis, autoimmune disease):
____
____

____________________________________ ______________________
Patient Name Date

____
Patient Signature

Do you have any problems with uncontrollable bowels/gas? Getting to the bathroom in time? Bowel Leakage? Constipation? If yes, please explain:

____

____

Social History:

Alcohol Use (circle): Never Rarely Moderate Daily

Tobacco Use (circle): Never Current Previously, quit (date)____________

Substance Abuse (circle): Never Current Previosly, quit (date)____________

If Current or Previous, what substance:___________________________________

<u>WOMEN ONLY</u>:

Date of last menstrual cycle? __________________

Are you pregnant? (circle) Yes No If yes, when is your due date: _____________

Are you breastfeeding? (circle) Yes No

How many children do you have? _____________

How many were vaginal births? _________ Of those, did you have a vaginal tear? Yes No

________________________________ ________________________
Patient Signature Date

________________________________ ________________________
Legal guardian signature if other than patient Date

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Consent to examination & treatment

I hereby authorize Dr. Robert West and such associates, technical assistants and other health care providers to perform a physical examination and treatment of my condition as recommended by the physician. I understand that base on my symptoms and exam findings, such procedures may include, but not limited to:

Hemorrhoid ligation/sclerosing/destruction by coagulation
Excision of external hemorrhoids or skin tags
Destruction of peri-rectal lesions via excision or cautery
Anorectal Physiology Testing and/or treatment

I consent to the administration of local anesthetics as deemed necessary or advisable by the physician. I also consent to laboratory examination and disposal of any tissue that may be removed during a procedure.

The procedure, potential risks, benefits and alternative treatments have been explained to me and my questions have been answered to my satisfaction. I understand and accept the risks and consequences associated with the proposed procedure, including but not limited to: discomfort, bleeding, infection and allergic reaction.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made regarding the results of the procedure.

I have read, or have had read to me, the contents of this form and as such I believe that I have adequate knowledge upon which to give my consent.

_______________________________________ _____________________________________
Patient Name (Print) Patient Signature

_________________ ____
Date Legal guardian signature if other than patient

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Patients have the responsibility to:

- Provide information needed to the professional staff in order to care for you, and to follow instructions and guidelines given by those providing health care services.
- Keep all scheduled appointments and be on time. Please give a 24 hour notice of cancelling or rescheduling. A $25.00 fee will be charged in some cases if appointments are not cancelled prior to 24 hours.
- Have a knowledge of your insurance benefits, deductibles, coinsurance and copayments.
- Pay your share of fees or co-payments at the time of service.
- Provide insurance information that is accurate and current.

Financial Policy

For patients with medical insurance, our office will file your medical claim to your insurance company for reimbursement to be made directly to our office. We must emphasize that as medical care providers, our relationship is with you and not your insurance company. Any patient financial responsibility deemed by your contract with your insurance company will be billed directly to the patient. This includes but not limited to: Copayment, Coinsurance, Deductible, Non-covered benefits, Ineligibility at the time of service. Most misunderstandings about insurance can be avoided if you understand what your insurance policies are.

In the event that your financial responsibility is not paid in a timely manner, every reasonable attempt to collect this debt will be made. This includes but is not limited to: statements/letters sent to your address on file, phone calls made to your home, cell phone and/or work. Once all attempts have been exhausted, your account will be placed with an outside collection agency and you will be responsible for reasonable collection costs and attorney fees associated with the cost of resolving your account.

For patients without medical insurance, payment in full is due at the time of service unless financial arrangements have been made with our office.

Statement of financial responsibility

I have read the above and are aware that medical charges incurred by me or my dependents for services rendered by Robert M. West, D.O. and/or his associates, are my financial responsibility. This also may include any outside laboratory fees needed for diagnostic tesing.

I hereby assign payment of authorized medical and/or surgical benefits to include major medical benefits to which I am entitled, to be made on my behalf to Robert M. West, D.O. and/or his associates for any services rendered by that physician. I authorize the release of medical information to the insurance company that is needed to determine these benefits payable to the related services.

Patient Name (print): ____

____________________________________ ___________________
Patient Signature (or Legal Guardian) Date

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Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I have been provided with a Notice of Privacy Practices, effective September 23, 2013, that provides a more complete description of my health information uses and disclosures. This Notice replaces the previous Notice of 2003. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations. I understand that the refusal to sign this consent or my request for restrictions will not affect my treatment however I may be personally responsible for payment of services.

I request the following restrictions and/or additional permissions of the use of my health information. (e.g. family members you give us permission to speak with regarding your care):
____
____
____
____
____

This authorization will remain valid unless changed by me in writing to Robert M. West, D.O.

____ ___________________________
Patient Name (print) Date

____ ____________________________
Patient Signature Witness

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