

# Colon & Rectal Surgeons of Greater Hartford, LLC

## PATIENT INFORMATION

PLEASE PRINT CLEARLY

Pt. No. \_\_\_\_\_

Patients Name \_\_\_\_\_ Sex M/F \_\_\_\_\_ Marital Status \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Home Phone# \_\_\_\_\_  
Zip Code \_\_\_\_\_ S.S.# \_\_\_\_\_ Driver's Op. # \_\_\_\_\_  
Employer Name \_\_\_\_\_ Work Phone# \_\_\_\_\_ Ext. \_\_\_\_\_  
Employer's Address \_\_\_\_\_ Occupation \_\_\_\_\_  
Referring Doctor \_\_\_\_\_ Primary Doctor \_\_\_\_\_  
Nearest Relative (not living with you) \_\_\_\_\_ Phone # \_\_\_\_\_

Primary Insurance Company \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Employer's name \_\_\_\_\_  
Insurance I.D. # \_\_\_\_\_ Policy/Group # \_\_\_\_\_  
Secondary Insurance Company \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Employer's name \_\_\_\_\_  
Insurance I.D. # \_\_\_\_\_ Policy/Group # \_\_\_\_\_  
Comments \_\_\_\_\_

### MEDICAL HISTORY

Previous Surgery: \_\_\_\_\_  
Do you have any history of disease of the heart, lungs, kidney, high blood pressure? \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_  
Do you have family history of heart disease, cancer, or diabetes? \_\_\_\_\_  
If yes, please explain \_\_\_\_\_  
Are you taking any medications now? (please specify) \_\_\_\_\_  
Are you allergic to any medications? \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I hereby authorize release of any medical information necessary to process my insurance claim, and request payment of medical benefits be made directly to **COLON & RECTAL SURGEONS OF GREATER HARTFORD** for services rendered to me by the above named physician and/or physician group.

I understand that any amount deemed by my insurance carrier to be beyond the "usual, reasonable and/or customary" charges for said services will be paid by me. I recognize and accept personal responsibility for immediate payment of charges not covered by my contract and agree to pay attorney's fees, court costs, and any other responsible costs of collection should I fail to make payment

Signature: \_\_\_\_\_ Date: \_\_\_\_\_