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

Please print

Last Name:_____Suffix____ First Name:_____ MI:___
Name preferred to be called:_____
Address:_____Apt #_____
City: _____State: _____Zip Code:_____
Home Phone # (_____)_____ Work # (_____)_____Cell # (____)_____
Preferred method of contact (circle): Home Work Cell
Email address (appointment reminders) :_____
Employer:_____ Occupation:_____
Birthdate:____/____/_____ SSN:_____-_____-_____
Marital Status (circle): Single Married Divorced Widowed Domestic Partner (living together) Other(specify) _____

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

Primary Insurance:_____ ID#:_____Group #:_____
Name of Insured:_____Relationship:_____Birthdate:_____
Secondary Insurance:_____ ID#:_____ Group #:_____
Name of Insured:_____Relationship:_____Birthdate:_____

Emergency Contact:_____ Relation: _____
Phone #:_____

PharmacyName:_____
Pharmacy Phone #/Cross Streets_____

_____ _____
Patient/Guardian Signature Date

15510 Olive Blvd. Ste 115
Chesterfield, MO 63017

6420 The Cedars Court
Cedar Hill, MO 63016

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Race: (please check)
- American Indian
- Asian
- Black or African American
- Hispanic
- Pacific Islander
- White
- Other:_____

Ethnicity: (please check)
- Hispanic
- Not Hispanic
- Unknown

Language: (please check)
- English
- Spanish
- Bosnian
- Other _____

Translator needed (other than English)? (please circle) Yes No

Current Gender Identity: (check all that apply)
- Male
- Female
- Additional category (please specify)_____

What sex were you assigned at birth? (check one)
- Male
- Female
- Other (please specify)_____

What pronouns do you prefer that we use when speaking to or about you?
- She/her/hers
- He/him/his
- They/them/theirs
- Other: Please specify:_____

_____ _____
Patient/Guardian Signature Date

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Patient History:

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):_____

_____

List of Medications (including blood thinners and over the counter medications/vitamins):

Check box if applies: ☐ Separate list provided ☐ Not taking any medications

Medication:	Reason for taking:	Prescribed by:

Allergies (Medication and Food)

☐ Check box if you have no allergies.

Name of Medication/Food	Reaction	Onset Date

_____ _____

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Medical History

	Date:	Results:	Name of Doctor/Where
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, with dates, that you have had (include any pacemaker or any metal implants):
_____
_____
_____

Any personal or family history of negative reactions to anesthesia medications? If yes, please explain._____
_____

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 Previously, quit (date)_____
If Current or Previous, what substance:_____

WOMEN ONLY:
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/Guardian Signature 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 based on my symptoms and exam findings, such procedures may include, but not limited to:

Hemorrhoid ligation/sclerosing/destruction by coagulation
Anorectal Dilation
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.

Any office procedures done are considered surgical, therefore they may be applied to any applicable deductible and/or coinsurance. Most misunderstandings about insurance can be avoided if you understand what your insurance policies are.

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

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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.
- 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. **Any office procedures done are considered surgical, therefore they may be applied to any applicable deductible and/or coinsurance. 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 testing.

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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