REV. 11/30/12

BENRUS SURGICAL at BARNES JEWISH ST. PETERS
PRIVACY POLICY INFORMATION

Do you authorize us to release any information to any other person or persons (spouse, friend, or roommate)? No information, such as test results or appointment changes, can be given to any other person unless listed. List name and relation:

1) _____
2) _____
3) _____

May we leave a detailed message regarding test results or other information on your voice mail?

Yes_____ No_____

If your disability insurance carrier requests information about you, either verbally or in writing, may we provide requested information?

Yes_____ No_____

Acknowledgement of Receipt of Privacy Notice

I have been given the opportunity to read a copy of **Benrus Surgical at Barnes Jewish St. Peters Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____
_____
_____

Signed: _____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed by: _____

Benrus use only:
If patient or patient's representative refuses to sign acknowledgement of privacy notice, please document the date and time the notice was presented to the patient and sign below.

Presented on (date and time):_____

By (name and title): _____

REV. 11/30/12

BENRUS SURGICAL at BARNES JEWISH ST. PETERS
INFORMED CONSENT TO TREATMENT AND/OR SURGICAL PROCEDURE

It is very important to Benrus Surgical at Barnes Jewish St. Peters that you understand and consent to the treatment your doctor is rendering and any procedure your doctor may perform. You should be involved in any and all decisions concerning surgical procedures your doctor has recommended.

I hereby authorize the Physician(s) of Benrus Surgical at Barnes Jewish St. Peters or assistants to the doctor to provide treatment and/or procedures the physician deems appropriate and will discuss with me and/or my Authorized Representative. However, I understand there is no certainty I will achieve the benefits and no guarantee has been made to me regarding the outcome of the treatment and/or procedure(s). I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well being and safety.

I understand there are risks and possible undesirable consequences associated with any procedure including, but not limited to, blood loss, transfusion reactions, infection, heart complications, blood clots, loss of or loss of use of body part, other neurological injury and/or death. I understand if I need blood or blood products these carry a risk of contracting HIV/AIDS, hepatitis or other diseases.

In permitting my doctor to provide treatment and/or perform the procedure(s), I understand unforeseen conditions may be revealed that may necessitate change or extension of the original procedure(s) or a different procedure(s) than those already explained to me. I therefore authorize and request the physician, his assistants, or his designees perform such procedure(s) as necessary and desirable in the exercise of his/her professional judgment.

In the unlikely event one or more of the above inherent complications may occur, my physician(s) will take appropriate and reasonable steps to help manage the clinical situation and be available to me and my family to address our concerns and questions.

I hereby authorize the doctor to utilize or dispose of removed tissues, parts or organs resulting from the treatment/procedure(s).

I consent to any photographing or videotaping of the procedure(s) performed, provided my identity is not revealed by the pictures or by descriptive texts accompanying them, so my physician may follow my therapy progression. I consent to the admittance of students or authorized equipment representatives to the procedure room for purposes of advancing medical education or obtaining important product information.

By signing below, I. the Patient/Authorized Representative have read this form or had it read to him/her. I also certify, as the Patient/Authorized Representative, that I (he/she) understand this information.

_____ _____

Signature of Patient/Authorized Representative Date/Time

_____ _____

Relationship, if other than patient signs Signature of Witness

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Certification of Physician:

I hereby certify I have discussed with the individual granting consent, the facts, anticipated benefits, material risks, alternative therapies and the risks associated with the alternatives of the treatment/procedure(s).

_____ _____

Signature of Physician Date/Time

Patient Demographic Form

In order to better serve our patients, and to update our records, please complete this basic information form:

Name: _____

Date of Birth: _____/_____/_____

Race:

__ Alaskan Native __Hispanic __Spanish American

__Asian __Native American __Unknown

__Asian Pacific __Other __White /Caucasian (Not Hispanic)

__Black/African American (Not Hispanic) __Pacific Islander

Ethnicity: __Hispanic or Latino __Not Hispanic or Latino __Unknown

Preferred Spoken Language:

__Arabic
__Bulgarian
__Central Khmer
__Chinese
__English
__French
__German
__Haitian/Haitian Creole
__Hebrew
__Hindi
__Italian
__Japanese
__Korean
__Polish
__Portuguese
__Russian
__ Somali
__Spanish/Castilian
__Swahili
__Thai
__Urdu
__Vietnamese

__Other (Please specify) _____

Benrus Surgical
at Barnes Jewish St. Peters

Patient History
Dr. Miller Patients

ALL QUESTIONS MUST BE ANSWERED

Name: _____ Age:_____ Date:_____
What is your primary problem? How long has it been going on? _____
_____

Please indicate if you have had any of the following:

Rectal pain	Y/N	Constipation	Y/N
Rectal bleeding	Y/N	Diarrhea	Y/N
Itching/Burning	Y/N	Blood in Stool	Y/N
Protrusion/Swelling	Y/N	Change in bowel habits	Y/N
Discharge	Y/N	Fecal Incontinence	Y/N
Abdominal Pain	Y/N	Diverticulosis	Y/N
Nausea	Y/N	Vomiting	Y/N

Have you had a Colonoscopy? _____ When?/Where?_____
How often do you move your bowels? _____
Do you need to take antibiotics before surgical or dental procedures? Why?_____
Have you ever been treated for the following: Chlamydia Y/N Gonorrhea Y/N
Syphilis Y/N Venereal Warts Y/N Herpes Y/N HIV/AIDS Y/N Hepatitis Y/N
Have you ever received Radiation Therapy or Radiation Seeds for any reason such as prostate cancer or Cervical cancer? Explain? Y/N _____

Current Medications

_____
_____
_____
_____
_____
_____
_____
_____

Allergies (meds, Latex)

_____
_____
_____
_____
_____

Social History: Tobacco Y/N Amount? _____
Alcohol Y/N Amount? _____

Surgical History

_____
_____
_____
_____
_____

Medical/Family History:

(Do you or your family have any of the following problems?)

	Patient	Family
Colon Cancer	____	____
Colon Polyps	____	____
Ulcerative Colitis	____	____
Crohns disease	____	____
Other cancers	____	____
Heart Disease	____	____
Hypertension	____	____
Diabetes	____	____
Stroke	____	____
Lung Disease	____	____
Liver Disease	____	____
Kidney Disease	____	____
Blood clotting problems	____	____

Physician Signature_____

Review of Systems

General	Weight loss	Y/N
	Sleep Apnea	Y/N
Neurologic	Dizziness	Y/N
	Light-headed	Y/N
	Weakness	Y/N
Eyes	Vision changes	Y/N
ENT	Hearing changes	Y/N
Cardiac	Chest Pain	Y/N
	Chest pressure	Y/N
	Tightness	Y/N
	Palpitations	Y/N
Respiratory	Shortness of Breath	Y/N
	Coughing	Y/N
	Wheezing	Y/N
Urinary tract	Frequent urination	Y/N
	Burning	Y/N
	Inability to urinate	Y/N
Musculoskeletal	Leg swelling	Y/N
Lymph	Swollen glands	Y/N
Hematologic	Easy bruising	Y/N
Skin	Rashes	Y/N