Dear Patient,

Thank you for choosing Colon and Rectal Specialists. Our records indicate that it is time to schedule your next colonoscopy. Since we do not require you to come in to have an office visit prior to your colonoscopy, it is important that we are able to update your medical history as well as your demographic and insurance information. Please complete and return this form ALONG WITH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD to **7425 Lee Davis Road, Mechanicsville, VA 23111 OR fax to 804-559-3362**. Upon receipt, we will call you to schedule your colonoscopy.
If you do not wish to schedule your colonoscopy at this time please fill out your name and DOB and fill out the deferral section at the bottom. If you have any questions please call us at **804-249-2465**.

Patient's Name:_____

Date of Birth:_____Phone # _____

Alternate Phone # _____

Email: _____

Address: _____

_____

Height:_____ Weight:_____

Insurance Information:

Primary Insurance Name:_____

Subscriber :_____

ID #:_____

Claims Address (found on back of ID Card):

_____

_____

Secondary Insurance Name:_____

Subscriber:_____

ID #:_____

Claims Address (found on back of ID Card):

_____

_____

Please list any new operations that you have had since your last visit:

1._____

Date of Surgery:_____

2. _____

Date of Surgery:_____

3. _____

Date of Surgery:_____

Please list any new Medical Problems that you have had since your last visit:

1._____

2. _____

3. _____

Current Medications (including Herbal and OTC):

Medication	Dosage	Frequency
1._____		
2._____		
3._____		
4._____		
5._____		
6._____		
7._____		
8._____		
9._____		
10._____		
11._____		

Drug Allergies:_____

_____

_____

_____

Privacy Practices: Our Notice of Privacy Practices is found online at: www.crspecialists.com. If you would like to request one be mailed to you, please call 804-249-2465.

Emergency Contact: _____

Contact #: _____

Administrative Services Policies

- There is a $25 fee for checks returned for insufficient funds or closed accounts.
- If you would like a copy of your medical records please call 804-249-2465. You must sign a medical release form and there is a fee of $10 plus $.50 per page.
- There is a $20 fee for completion of all forms including FMLA, disability, etc.

ALL SCHEDULED COLONOSCOPIES CANCELLED OR RESCHEDULED WITH LESS THAN FIVE (5) BUSINESS DAYS NOTICE WILL INCUR A $100 FEE.

By signing below I acknowledge that I have received, reviewed, understand and will comply with all of the policies set forth above.

_____ _____
Signature Date

❑ I wish to defer my colonoscopy at this time. Reason:

_____

_____

Signature:_____

Please indicate your preferred pharmacy to send the prescription for your colonoscopy prep.

Pharmacy Name:_____

Address:_____

_____

Phone Number:_____

E- prescriptions are computer generated prescriptions that are sent directly to your pharmacy. By signing this form you agree that Colon and Rectal Specialists, Ltd. may use e-prescribe and may request and use your prescription medication history from other health care providers or third-party pharmacy benefits payers for treatment purposes.

❑ Please use e-prescribe
❑ Please do not use e-prescribe. I want to come to the office and pick up a written prescription