Dear Patient,

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 to our office at 8700 Stony Point Pkwy, Suite 270, Richmond, VA 23235.

Patient Name:_____

DOB:_____ Phone Number:_____

Height:_____ Weight:_____

Primary Insurance Name:_____
ID #:_____
Claims Address (found on back of ID Card):
_____
_____

Secondary Insurance Name:_____
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:_____
_____
_____

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

Pharmacy Name:_____
Address:_____
_____
Phone Number:_____

E- Prescriptions are computer generate prescriptions created by your provider and sent directly to your pharmacy through a HIPAA (Health Insurance Portability and Accountability Act) secure connection. By signing this form you agree that Colon and Rectal, Ltd. may use e-prescribe and may request and use your prescription medication histor 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 tc the office and pick up a written prescription

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.

Administrative Services Policies

- There is a $25 fee for checks returned 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