**Barbara Ann Scherer, M.D., P.A.**
2001 East Commercial Blvd., Ft. Lauderdale, FL 33308
**954.771.3737 Fax 954.771.9980 www.BASMD.com**

# Please Print this Out

## Proctology Patients

Please Read and Fill Out the Following Forms and Fax
or bring with you on Your Appointment

## FAX: 954.771.9980

# Barbara Ann Scherer, M.D.,P.A.

*Proctology*

2001 E. COMMERCIAL BLVD. • FT. LAUDERDALE, FL 33308 • (954) 776-5484


## *CONSENT TO TREATMENT*

I have been informed by Barbara A. Scherer, MD

of the risks, possible alternative methods of treatment, and

possible consequences involved in the treatment by means of:

***Sigmoidoscopy with possible Hemorrhoidectomy and/or polypectomy***

for the relief of ***proctologic symptoms.***

Understanding this, I hereby authorize the above named doctor

to administer such treatment to

me (_or ______________________________________________).
*name of patient, if minor*

Signed ______________________________________________
*patient or authorized to consent for patient*

Witness ______________________________________________

Date ______________________________

## Patient Authorization and Assignment of Benefits Form

Commercial Insurance And Managed Care Members Lifetime Authorization

I authorize the release of any medical information necessary to process my insurance claim(s). I request that the payment authorized be made on my behalf, and I assign the benefits payable for physician services to Barbara Ann Scherer, MD, PA. I request that this authorization apply to all insurance claims, present and future. In consideration of the provision of medical services, I assume full responsibility for all physician charges for such medical services rendered to myself, derived from deductible and co-insurance amounts as well as any amounts not covered by my insurance carrier, from the actual physician charges. I have been advised that pursuant to 42 C.F.R., Section 405.420, the physician is authorized and obligated to undertake reasonable collection efforts, such as submitting follow-up letters, and engaging in personal and telephonic amounts due and owing pursuant to the rendering of medical services to myself. Further, I agree that, I will be responsible for all collection costs, attorney fees and court costs should this account be referred to an attorney or collection agency. In the event that I am unable to pay my bill, I will report in writing to the physician my inability to pay prior to services being rendered.
**Initials:**__________

**HMO/PPO Acceptance**: I certify that I am enrolled in______________________________ Health Maintenance Organization (HMO)/Preferred Provider Organization (PPO). I understand that if I change HMO/PPO enrollment I must notify Barbara Ann Scherer M.D., P.A. immediately. Subsequent rejection of a claim as a result of failure to notify us of this change will constitute responsibility for payment of claim on my part.
**Initials:**___________

**HMO/PPO Disclaimer:** I certify that I am not enrolled in any Health Maintenance Organization (HMO)/Preferred Provider Organization (PPO). Subsequent rejection of a claim due to current enrollment in a HMO will constitute responsibility for payment of claim on my part.
**Initials:**___________

_____________________________________ _________________________________

Signature of Insured Print Patient/Insured's Name

____________________________________

Today's Date

**Barbara Scherer, M.D., P.A.**
2001 East Commercial Boulevard
Fort Lauderdale, Florida 33308

# REGISTRATION FORM

*Please Print*

Today's Date______________ Home Phone (____)________________

Name ____________________________________________________ Sex: Male Female
First Middle Last

Local Address_________________________________________________________________

City __________________________ State _____________ Zip Code___________________

Work Phone (____)________________ Beeper/Cellular Number (_____)________________

Social Security Number_______-_____-________ Date Of Birth____/____/_____ Age_______
Month Day Year

Marital Status: Single Married (Spouse's Name____________) Widowed Divorced

Place of Employment_______________________________ Occupation__________________

Address____________________________________________________________________
Street City Zip Code

Primary Language Spoken___________________ Secondary Language___________________

Person To Contact in Case Of Emergency:__________________________________________

Phone (______)_____________ Relationship______________________

How did you learn of our practice?__________________________

Primary Insurance Company____________________________________________________

*Please return this completed form (front and back), with your insurance card and your driver's license to the receptionist.*

*Thank You*

# Barbara Ann Scherer, M.D., P.A.

*Proctology*

## Comprehensive History Questionnaire

Name ______________________________ Today's Date ______________

### CURRENT MEDICAL PROBLEMS

Please list the **current** proctologic problem(s) for which you came to see the doctor. About when did they begin?

Problems Date Began

______________________________

______________________________

______________________________

### OTHER MEDICAL CARE:

If you are being treated for any other illness or medical problems by another physician or physical or mental health practitioner, please describe the problems and write the name of the physician, health practitioner or medical facility treating you. Use back page if more space is needed.

Check if used ❑

Illness or Medical Problem | Physician or Medical Facility | Address

______________________________

______________________________

______________________________

### PAST SURGERIES:

None ❑ Blood Transfusions Yes ❑ No ❑

❑ List here any past surgeries with approximate age: ______________________________

### CURRENT MEDICATIONS

Please list all medications you are now taking, including those you buy without a doctor's prescription (such as aspirin, cold tablets or vitamin supplements). List name, dosage, and times per day.

1. ______________ 4. ______________ 7. ______________
2. ______________ 5. ______________ 8. ______________
3. ______________ 6. ______________ 9. ______________

### CURRENT ALLERGIES, SENSITIVITIES AND INTOLERANCES

List anything that you are allergic to such as certain foods, medications, dust, chemicals, soaps, household items, pollens, bee stings, etc. and indicate how each affect you. ______________________________

______________________________

### SOCIAL:

Intake of Coffee/Tea_____cups/day_____years

Hours of Sleep_________/day

Excercise Regulary? Yes ❑ No ❑

❑ Smoke Cigarettes_____packs/day/_____years

❑ Ex-Smoker_____pack/days_____years

❑ Alcohol (❑ Occasional, ❑ Social, ❑ Rare)______drinks/day_____years

### PAST ILLNESSES: No serious past illnesses ❑

❑ Hypertension ❑ Heart Attack

❑ Diabetes ❑ Asthma

❑ High Cholesterol ❑ COPD/Emphysema

______________________________

List any serious illnesses, with approximate age:

______________________________

______________________________

______________________________

Have you ever had a:

Barium Enema? ❑ NO ❑ YES If yes, when/results ______________________________

Flexible Sigmoidoscope? ❑ NO ❑ YES If yes, when/results ______________________________

Colonoscopy? ❑ NO ❑ YES If yes, when/results ______________________________

Colon Polyp? ❑ NO ❑ YES If yes, when/results ______________________________

# PATIENT/PROVIDER CHECKLIST FOR MEDICAL HISTORY

**FAMILY HISTORY:** If any of the following run in your family, check appropriate box, and in whom:

- ❑ Cancer ______________________ ❑ Hypertension ______________________
- ❑ Heart Disease ______________________ ❑ Strokes ______________________
- ❑ Diabetes ______________________ ❑ Alcoholism ______________________
- ❑ Thyroid Disease ______________________ ❑ Colon Polyps ______________________
- ❑ Other ______________________

**REVIEW OF CURRENT SYMPTOMS:** Place a checkmark in the appropriate boxes in the following list of **current** symptoms.

**MD/Provider Notes**

## 1. HEAD AND NECK

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Headaches | ❑ | ❑ | Ringing in ears | ❑ | ❑ | Chronic nose obstruction | ❑ | ❑ |
| Vision glasses | ❑ | ❑ | Pain in ears | ❑ | ❑ | Chronic sore tongue | ❑ | ❑ |
| Eye pain | ❑ | ❑ | Discharge from ear | ❑ | ❑ | Persistent sore gums | ❑ | ❑ |
| Double Vision | ❑ | ❑ | Repeated nosebleeds | ❑ | ❑ | Prolonged hoarseness | ❑ | ❑ |
| See "floating lights" | ❑ | ❑ | Teeth problems | ❑ | ❑ | Persistent neck regidity | ❑ | ❑ |
| Severe hearing loss | ❑ | ❑ | Frequent colds | ❑ | ❑ | Swellings in neck | ❑ | ❑ |

## 2. HEART - CARDIOVASCULAR

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Heart problems | ❑ | ❑ | Chest pain on effort | ❑ | ❑ | Ankles swell | ❑ | ❑ |
| Hypertension | ❑ | ❑ | Skipping/irregular heartbeats | ❑ | ❑ | Difficult breathing | ❑ | ❑ |

## 3. PULMONARY - LUNGS

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Sit up to breathe easier | ❑ | ❑ | Spit up blood | ❑ | ❑ | Wheezing | ❑ | ❑ |
| Have chronic cough | ❑ | ❑ | Frequent chest colds | ❑ | ❑ | Have night sweats | ❑ | ❑ |

## 4. STOMACH AND INTESTINES

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Chronic abdominal pain | ❑ | ❑ | Vomit blood | ❑ | ❑ | Any blood from rectum | ❑ | ❑ |
| Persistent nausea | ❑ | ❑ | Skin turns yellow | ❑ | ❑ | Clay covered stools | ❑ | ❑ |
| Heartburn | ❑ | ❑ | Any chronic diarrhea | ❑ | ❑ | Habitual constipation | ❑ | ❑ |
| Appetite loss | ❑ | ❑ | Any black tarry stools | ❑ | ❑ | Have hemorrhoids | ❑ | ❑ |
| Bloating | ❑ | ❑ | Anal/Rectal itch | ❑ | ❑ | Change in bowel habits | ❑ | ❑ |

## 5. URINARY TRACT - ETC.

OBGyn (For women only)

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Frequent urination | ❑ | ❑ | Pain with urination | ❑ | ❑ | Painful menstruation | ❑ | ❑ |
| Hard to start urinary flow | ❑ | ❑ | Any leakage of urine | ❑ | ❑ | Excess menstruation | ❑ | ❑ |
| Scanty urination | ❑ | ❑ | Passed any stones | ❑ | ❑ | Bleed between periods | ❑ | ❑ |
| Any blood in urine | ❑ | ❑ | Any bedwetting | ❑ | ❑ | Any missed periods | ❑ | ❑ |
| Frequent night urination | ❑ | ❑ | Any retention of urine | ❑ | ❑ | Last menstrual period_______ | | |
| | | | Men - Prostate problem | ❑ | ❑ | Number of pregnancies_______ | | |
| | | | | | | Number of living children_______ | | |

## 6. MUSCLES - JOINTS

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Phys. handicapped/limited | ❑ | ❑ | Any tingling sensations | ❑ | ❑ | Any paralysis | ❑ | ❑ |
| Joint or muscle problems | ❑ | ❑ | Any numbness | ❑ | ❑ | Any shaking | ❑ | ❑ |
| Shoulder pain | ❑ | ❑ | Disturbance in walking | ❑ | ❑ | Any strokes | ❑ | ❑ |
| Back pain | ❑ | ❑ | Any muscle jerking | ❑ | ❑ | Any seizures | ❑ | ❑ |

## 7. NEUROPSYCHOLOGICAL

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Depression | ❑ | ❑ | Paralysis/weakness | ❑ | ❑ | Psychotherapy/counseling | ❑ | ❑ |
| Nervous breakdown | ❑ | ❑ | Any memory loss | ❑ | ❑ | Any alcohol problem | ❑ | ❑ |
| Any mental problems | ❑ | ❑ | Personality changes | ❑ | ❑ | Any drug problem | ❑ | ❑ |
| Dizzy spells | ❑ | ❑ | Speech disturbances | ❑ | ❑ | Serious mental problem | ❑ | ❑ |

If there are any additional health factors in your history or if any of the above points need clarifying use this space for additional comments.

______________________________________________________________

______________________________________________________________