SOUTH FLORIDA COLORECTAL INSTITUTE

ELIE SCHOCHET, M.D.

PATIENT REGISTRATION FORM

Patient Name: _____ Social Security (last 4 digits only): xx – xx – _____

Date of Birth: _____/_____/_____ Age: _____ Sex: M / F / T / Other Married / Single / Partner / Divorced / Widow(er)

Phone: (_____) _____ - _____ Email: _____

Address: _____
(Street) (City/State/Zip)

Preferred Pronoun: _____ Race: _____ Ethnicity: _____

Employer Name: _____ Employer Phone: (_____) _____ - _____

Primary Care Physician: _____ How did you hear about our Practice? _____

Pharmacy: _____
(Street) (City/State/Zip)

Cell Phone Carrier (for Text appt confirmation): ATT METRO SPRINT TMOBILE VERIZON Other: _____

Person responsible for bill (*Complete only if different from patient*)

Guarantor Name: _____ Guarantor Phone: (_____) _____ - _____

Relationship to Patient: (please check): ( ) spouse ( ) parent ( ) partner Date of Birth: _____/_____/_____

Address: _____
(Street) (City/State/Zip)

Emergency Contact

Name: _____ Relationship: _____

Home Phone: (_____) _____ - _____ Alternate Phone: (_____) _____ - _____

PRIMARY INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder's Name (write SELF if patient): _____

Policy Holder's Social Security Number: _____ - _____ - _____ Policy Holder's Date of Birth: _____/_____/_____

SECONDARY INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder's Name (write SELF if patient): _____

Policy Holder's Social Security Number: _____ - _____ - _____ Policy Holder's Date of Birth: _____/_____/_____

I acknowledge that I am ultimately financially responsible for payment whether or not services are covered by my insurance. I acknowledge that any out-of-pocket costs (ie; deductible, coinsurance, copayment, denials from insurance carrier, etc) incurred from services rendered by Dr. Elie Schochet are my responsibility. By signing below, I understand and comply with the above statements regarding my financial responsibility to South Florida Colorectal Institute, Elie Schochet, M.D.

Signature: _____ **Date:** _____

1930 NE 47TH Street · Suite 104 · Fort Lauderdale, FL 33308
954.573.1499 · Fax 954.903.0338
www.sflcolorectal.com

SOUTH FLORIDA COLORECTAL INSTITUTE
ELIE SCHOCHET, M.D.

Cancellation and No-Show Policy

Our goal is to provide quality individualized medical care in a timely manner. No-Shows create an inconvenience for the practice and prevent scheduling of other patients who need access to medical care in a timely manner. We understand situations arise when you may need to cancel your appointment and we appreciate advance notice when that happens. This helps us be respectful of other patients needs and enables us to give the appointment time to another patient who needs to see us.

We require notification by 2:00 pm on the business day prior to your scheduled office appointment if you need to reschedule or cancel, otherwise the patient will be responsible for the following fee(s):

No-show / cancelled office appointment **without** the above advanced notice **$50.00 Fee**

No-show / cancelled in- office procedure **without** the above advanced notice **$100.00 Fee**

This fee will not be submitted to insurance. It is your responsibility and must be paid in full prior to scheduling your next appointment.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

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CONSENT FOR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Elie Schochet,M.D. / South Florida Colorectal Institute may use and/or disclose all of your health information in our possession (referred to as "Protected Health Information") necessary in connection with your treatment and/or obtaining payment for treatment and services that we provide for you, so that we may conduct our health care operations per the Notice of Privacy Practices. You have the right to review our Notice of Privacy Practices Form prior to signing this consent. At times this form may be revised without notice. Carefully review the Notice of Privacy Practices form as it contains a list of rights that are available to you with respect to the use and disclosure of your protected health information including your right to request restrictions on our use and disclosure of your protected health information. You have the right to revoke this consent at any time. If you wish to revoke this consent, you must do so in writing. By signing below, you acknowledge that you have read and understand the South Florida Colorectal Institute Notice of Privacy Practices Form and authorize the release of any medical information necessary to process applicable bills to your insurance company, and request payment of benefits to South Florida Colorectal Institute.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

PHI may also be released to: (incl but not limited to billing, appt, medical info)

[ ] Spouse / Partner _____
[ ] Child(ren) _____
[ ] Others _____
[ ] Information is not to be released to anyone.

RESEARCH DISCLOSURE AUTHORIZATION

For future research purposes, all or part of your medical records may be reviewed by other physicians, other national health authorities (where applicable), and/or representatives of pharmaceuticals companies. Information from this study may be published in scientific journals or presented at scientific meetings. Your identity will be kept strictly confidential as stated in the section above. You can refuse to sign this consent authorization and not be part of future research studies. By signing this section of the consent form, you give us permission to use and/or share your health information as stated above.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

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SOUTH FLORIDA COLORECTAL INSTITUTE, PLLC
ACKNOWLEDGEMENT OF RECEIPT OF THE PRACTICE'S
NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of the Practice's Notice of Privacy Practices. You may refuse to sign this acknowledgement.

_____ _____ _____

Name (Print) Signature Date

Practice Use Only

Date acknowledgement received: _____

Individual refused to sign:_____ (check if applicable)

An Emergency situation prevented the Practice from obtaining acknowledgement: _____(check)

Other reason acknowledgement was not obtained: _____
_____

Practice Employee

Signature: _____

Print Name: _____

Date: _____

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WHAT TYPE OF COMPLAINT OR ISSUE IS THE REASON FOR REQUESTING THIS VISIT?

_____

Habits: Do you smoke? No_____Yes_____ If yes, how many packs per day? _____
If you have quit, how long ago? _____

Do you use alcohol? No_____Yes_____ If yes, how often do you drink? _____
If you have quit, how long ago? _____

Do you use marijuana? No_____Yes_____ If yes, how often? _____
If you have quit, how long ago? _____

MEDICAL HISTORY:

Please list other diseases/conditions from which you are **currently** being treated for:

_____

_____

Please list other medical conditions from which you were treated for **in the past**:

_____

_____

Please list any surgeries (operations), reason for the surgery, and year of surgery **including last colonoscopy**:

_____

_____

_____

_____

Please list any physicians who currently treat you or have treated you in the past and their specialty:

Name:_____Specialty: _____

Name:_____Specialty: _____

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ALLERGIES OR ADVERSE DRUG REACTIONS? Please list drug and type of reaction

_____

MEDICATIONS:

Prescription medications	Dose	How often taken	Prescribed for? (condition)

NON-PRESCRIPTION (over-the-counter medications such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

FAMILY HISTORY:

Place an "X" in appropriate boxes to identify all illnesses/conditions in your **blood relatives**

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

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SYMPTOM REVIEW (Check all that apply)

Gastrointestinal
- ☐ poor appetite
- ☐ abdominal pain
- ☐ indigestion
- ☐ trouble swallowing
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habits
- ☐ nausea or vomiting
- ☐ rectal bleeding or blood in stools
- ☐ history of liver disease or abnormal liver tests

Cardiovascular
- ☐ chest pain
- ☐ history of angina or heart attack
- ☐ history of high blood pressure
- ☐ history of irregular beat
- ☐ history of poor circulation

Pulmonary/lungs
- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ asthma or wheezing

Muscle/joint/bone
- ☐ swelling of ankles or legs
- pain, weakness or numbness in
- ☐ arms or hands
- ☐ back or hips
- ☐ legs or feet
- ☐ neck or shoulders

Neurologic
- ☐ history of stroke
- ☐ blackouts or loss of consciousness

General
- ☐ weight gain/loss of 10+ lbs during last 6 months
- ☐ poor sleep
- ☐ fever
- ☐ headache
- ☐ depression

Eyes, ears, nose, throat
- ☐ blurred vision
- ☐ other change in vision
- ☐ history of glaucoma or cataracts
- ☐ loss of hearing
- ☐ sinus problems
- ☐ hoarseness

Genitourinary
- ☐ frequent or painful urination
- ☐ blood in urine

Skin
- ☐ itching
- ☐ easy bruising
- ☐ change in moles

Endocrine
- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather
- ☐ excessive thirst

- ☐ abnormal cervical Pap smear
- ☐ bleeding between periods
- date of last mammogram_____

- ☐ PSA
- ☐ abnormal anal Pap smear

Transfusions: Have you ever received a blood transfusion? No_____ Yes_____ When?_____

Immunizations: If YES, give approximate year given

Flu	No_____	Yes_____	Year _____
Pneumococcal	No_____	Yes_____	Year _____
Hepatitis A	No_____	Yes_____	Year _____
Hepatitis B	No_____	Yes_____	Year _____
HPV	No_____	Yes_____	Year _____
COVID	No_____	Yes_____	Year _____
MonkeyPox	No_____	Yes_____	Year _____

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