Patient Information

Name: _____ Date of Birth: _____

Mailing Address:_____

City:_____State:_____Zip_____

Home Phone:_____Work/Cell Phone:_____

Primary Insurance:_____ Policy #_____

Customer Service ph #:_____Name on Policy_____

Policy Holder's date of birth, if other than self:____/____/____.

Secondary Insurance: _____Policy #_____

Customer Service ph #:_____Name on Policy_____

Policy Holder's date of birth, if other than self: ____/____/____.

Primary Care Physician:_____

Phone:_____

Do you see a specialist? **YES** or **NO**

Do you have a family history of colon cancer? **YES** or **NO** Colon polyps? **YES** or **NO**

Do you take aspirin or any blood thinning medications? **YES** or **NO**

Please list all the **medications** that you take, including non-prescribed medications and any vitamins/ herbal supplements: (Including the dosage) (Use the back of this page if needed)

1._____ 8._____

2._____ 9._____

3._____ 10._____

4._____ 11._____

5._____ 12._____

6._____ 13._____

7._____ 14._____

Please indicate the **best time of the day** to reach you and **best daytime phone number** to contact you:_____

Please return these forms to our office in the enclosed, self addressed stamped envelope. You will be contacted to schedule or you may call the office at (515) 288-6097.
Thank you.

Revised 2/25/14