Wilton Surgery Center

Open Access Intake Form

REASON FOR VISIT: ASYMPTOMATIC _____ SYMPTOMATIC_____

HAVE YOU EVER HAD A COLONOSCOPY?_____ WERE THERE POLYPS FOUND?_____

NAME:_____ M: _____ F: _____

DATE OF BIRTH:_____MARITAL STATUS: __S __M __W __D

HOME PHONE: _____ CELL PHONE: _____

ADDRESS: _____ CITY / STATE / ZIP: _____

EMAIL: _____

PRIMARY CARE PHYSICIAN:_____

INSURANCE INFORMATION – PRIMARY INSURANCE
INS CO NAME: _____ MEMBER ID#: _____
NAME OF POLICY HOLDER: _____

DATE OF BIRTH OF INSURED: _____ RELATIONSHIP TO THE INSURED: _____

SECONDARY INSURANCE: (IF APPLICABLE)
PLAN NAME: _____ MEMBER ID#: _____
POLICY HOLDER: _____
DATE OF BIRTH OF POLICY HOLDER: _____RELATIONSHIP TO THE INSURED _____

MEDICATIONS:

_____
_____

HEIGHT: _____ WEIGHT: _____ BMI:_____
MEDICAL HISTORY: _____
HAVE YOU HAD A RECENT EKG? *YES* ___ *NO* ___ *IF YES, WHERE AND WHEN* _____
SURGICAL HISTORY:_____
_____

FAMILY HISTORY: COLON CANCER _____ COLON POLYPS _____ LIVER DISEASE _____ GALLSTONE _____
(ULCERATIVE COLITIS / CHRON'S) _____ PEPTIC ULCER DISEASE _____

Preference for M/F proceduralist?_____ Preference for Day of Week? ___M___T___W__TH ___ F ___or no preference

Office Use Only

PROCEDURE DATE: _____ TIME: _____
PROCEDURALIST:_____