Brent K. Evetts, M.D.

Patient Registration **Date:** ________________

Patient Information (please print)

Legal Name: ____

Address: ____

City: ____________________ State: ____________ Zip Code: ____________________

Telephone (Home): ____________________ Cellular: ________________________

Email: ____________________________ Date of Birth: ____________ Sex: M F

Employer: __________________________ Work: ____________________

Which number may we use to leave detailed messages? HOME WORK CELL

Social Security Number: ______________ Language Spoken: ____________________

Race: ____________________ Ethnicity: ________________

Primary Physician (PCP): ______________________ Office Phone: ________________

Who referred you? ____________________________ Telephone: ________________

Emergency Contact:

Name: _________________________ Relation: __________ Telephone: ______________

Preferred Pharmacy & Location: ___________________________ Telephone: __________

PRIMARY INSURANCE

Insurance Name: ________________________________ Co-pmt $: ______________

Subscriber Name: ____________________ DOB: __________ Relationship: __________

ID No. or Social Security No.: __________________ Group or Plan No.: ________________

SECONDARY INSURANCE

Insurance Name: ___________________________________ Co-pmt $: ____________

Subscriber Name: __________________ DOB: __________ Relationship: ____________

ID No. or Social Security No.: __________________ Group or Plan No.: ______________

Responsible Party (if under 18 years)

Person responsible for payment: (please circle) Self Spouse Father Mother Other

Name: _________________________ Relationship: ___________________________

Address: ____

City: _________________________ State: ______________ Zip Code: ___________

Willamette General & Colon-Rectal Surgery, P.C.

CREDIT POLICY

Patient Responsibility: Patients are responsible for all charges resulting from treatment provided by Clinic/Physician. As a service to you, we bill most insurance carriers directly. However, primary responsibility for the account is yours. Payment is due within 30 days of the first billing, unless other financial arrangements are made. Established patients with a delinquent balance may be asked for payment at time of service.

- Minors: Patients under 18 years of age will be the responsibility of the custodial parent(s).

Referrals: If your insurance requires a referral, from your Primary Care Provider (PCP), to see a specialist, it is your responsibility to obtain a referral/authorization prior to your appointment.

- A phone will be provided for your call. Please get the name of the person who authorizes your visit.

Insurance Billings: We will, as a courtesy, bill your primary insurance carrier. Providing correct insurance billing information is the responsibility of the patient. If your insurance changes, please present your new insurance information at your next visit.

Medicare: Our physicians are participating providers. Although we bill Medicare as your primary insurer, you may be responsible for billing your supplement insurance. Note: Medicare may be able to bill your supplemental insurance, please contact them at 1-800-633-4227.

Oregon Welfare & Oregon Health Plan: Please bring your current medical card with you to each appointment. If you are restricted to a primary care physician by Oregon's Medical Assistance Program or Washington's Department of Social and Health Services, you must obtain a referral to the specialist by them.

Check Returned: It is our office policy to charge all patients a $25.00 fee for checks that are returned.

Authorization to Release Information:

I have read and I accept this policy for my testing and/or treatment with Willamette General & Colon-Rectal Surgery, P.C. In obtaining payment for services, I authorize my healthcare provider, Willamette General & Colon-Rectal Surgery, P.C., to furnish information from my medical record to any company that may be responsible for payment of all or part of my provider charges, including my insurance companies and their representatives, and my employer or union if they are involved in processing the claim.

If I have been referred by, or am being referred to, another healthcare provider, I authorize Willamette General & Colon-Rectal Surgery, P.C. to release my clinical information to this provider for continuing care.

I also assign Willamette General & Colon-Rectal Surgery, P.C. all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days will be subject to a processing fee.

I, OR MY APPOINTED AGENT, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS. I MAY ASK FOR A COPY OF THIS INFORMATION FOR MY RECORDS.

____________________ ____________________ ____________

Patient Name (print) Patient's Signature Date

IF PATIENT IS UNDER THE AGE OF 15 YEARS, OR IS OTHERWISE UNABLE TO SIGN, COMPLETE THE FOLLOWING.

Patient is _____ year(s) of age or is unable to sign because: ____________________

____________________ ____________________ ____________

Signature Relationship to Patient Date

Sign Below if Disclosure of Information is not authorized:
Therefore, I agree to pay for costs of all treatment and services personally.

____________________ ________ ____________________ ________

Signature of Guarantor Date Signature of Patient Date

Willamette General & Colon-Rectal Surgery, PC

Patient History Form

☐ New ☐ Established

19875 SW 65th # 260
Tualatin OR 97062
(503) 691 - 1743
DrEvetts.com

Demographics

First Name: ______________ Last Name: ______________ Middle: ______

Date of Birth: _____ / _____ / _____ Age ______ Sex: ☐ Female ☐ Male

Today's Visit

Today's Date: _____ / _____ / _____

Reason for Todays Visit:

____

____

Who referred you: ______________________________

PCP:

☐ Same as referring

☐ ______________________________

Allergies

List Any Known Drug Allergies: ______________________________

Current Medications

☐ See list

Medication	Dose	Frequency	Medication	Dose	Frequency

Past Medical History (please check all appropriate boxes)

General

☐ **No active medical problems**
☐ Alcohol / drug abuse
☐ Anti-Coagulation treatment
☐ Anxiety
☐ Chronic pain
☐ Chronic pain medication use
☐ Drug abuse
☐ DVT - blood clot
☐ Fibromyalgia
☐ Sleep Apnea

Heart / Lungs

☐ Angina
☐ Arrythmia
☐ Asthma
☐ Atrial Fibrillation
☐ COPD
☐ History of Heart Attack
☐ Hypertension
☐ Murmur
☐ Valvular heart disease

Gastrointestinal

☐ Anal Fissure
☐ Anal Fistula
☐ Bowel obstruction
☐ Chronic Constipation
☐ Colon Polyps
☐ Crohn's Disease
☐ Diverticulits
☐ Hemorrhoids
☐ Irritable Bowel Syndrome
☐ GERD (Esophageal reflux)
☐ GI Bleed
☐ Peptic Ulcer Disease
☐ Ulcerative colitis
☐ ______________
☐ ______________

Miscellaneous

☐ Aids / HIV
☐ Alzheimer's
☐ Anemia
☐ Arthritis
☐ Autoimmune disease
☐ Cirrhosis - Liver Disease
☐ Diabetes - Type I
☐ Diabetes - Type II
☐ Hepatitis - A
☐ Hepatitis - B
☐ Hepatitis - C
☐ Kidney Disease
☐ Neurological disorder
☐ Osteoporosis
☐ Stroke
☐ Thyroid - Hyperthyroid
☐ Thyroid - Hypothyroid
☐ ______________

Cancer

☐ Bladder
☐ Bone
☐ Breast
☐ Cervical
☐ Colon
☐ Esophagus
☐ Leukemia
☐ Lung
☐ Mouth / Throat
☐ Ovarian
☐ Prostate
☐ Rectal
☐ Skin
☐ Stomach
☐ Uterine
☐ Prior Radiation treatment
☐ ______________
☐ ______________

Past Surgical History (please check all appropriate boxes)

General:
- ☐ **No Prior surgery**
- ☐ Anesthesia problems- No
- ☐ Anesthesia problems- Yes
- ☐ Surgical complications -No
- ☐ Surgical complications - Yes
- ☐ Post op delerium

Gastrointestinal:
- ☐ Appendectomy
- ☐ Anal Fissure
- ☐ Anal Fistula
- ☐ Bowel obstruction
- ☐ Colon resection - Cancer

Gastrointestinal:
- ☐ Colon resection - Other
- ☐ Gallbladder - Open
- ☐ Gallbladder - Laparoscopic
- ☐ Hemorrhoidectomy
- ☐ Rectal surgery
- ☐ Stomach surgery

GYN:
- ☐ C-Section
- ☐ D & C
- ☐ Hysterectomy with ovaries
- ☐ Hysterectomy alone
- ☐ Pelvic Floor
- ☐ Bladder

Cardio / Pulmonary
- ☐ Aortic valve
- ☐ CABG
- ☐ Cardiac Cath
- ☐ Cardiac stent
- ☐ Carotid
- ☐ Endovascular stent
- ☐ Lung Surgery
- ☐ Mitral valve

Orthopedic
- ☐ Back Surgery
- ☐ Hip replacement
- ☐ Knee arthroscopy
- ☐ Knee replacment
- ☐ Neck surgery

Miscellaneous:
- ☐ Breast
- ☐ Inguinal hernia - open
- ☐ Inguinal hernia - laparoscopic
- ☐ Incisional hernia
- ☐ Kidney surgery
- ☐ Mastectomy
- ☐ Prostatectomy
- ☐ Tonsillectomy
- ☐ TURP
- ☐ Umbilical hernia
- ☐ Vascular surgery
- ☐ ____________________
- ☐ ____________________

Family History (please check all appropriate boxes)

- ☐ None
- ☐ Alcoholism
- ☐ Anesthetic complications
- ☐ Anxiety
- ☐ Blood clots
- ☐ Colon Polyps
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes
- ☐ Heart disease
- ☐ Ulcerative colitis
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

Cancer
- ☐ Breast
- ☐ Cervical
- ☐ Colon
- ☐ Esophagus
- ☐ Leukemia
- ☐ Lymphoma

Cancer
- ☐ Lung
- ☐ Mouth / Throat
- ☐ Ovarian
- ☐ Prostate
- ☐ Rectal

Cancer
- ☐ Skin
- ☐ Stomach
- ☐ Uterine
- ☐ ____________
- ☐ ____________

Social History / Risk Factors (please check all appropriate boxes)

Marital Status
- ☐ Single
- ☐ Married
- ☐ Significant other
- ☐ Widowed

Living situation
- ☐ Live alone
- ☐ Live with family
- ☐ Live with caregiver
- ☐ Assisted Living

Occupation
- ☐ Employed full time
- ☐ Employed Part time
- ☐ Self employed
- ☐ Disabled
- ☐ Homemaker
- ☐ Retired
- ☐ Student
- ☐ Unemployed
- ☐ ____________________

Tobacco Use
- ☐ Never smoked
- ☐ Current every day
- ☐ Occasional use
- ☐ Former smoker
- ☐ Smokeless tobacco

Drug use
- ☐ Yes
- ☐ No

HIV high risk behavior
- ☐ Yes
- ☐ No

Alcohol Use
- ☐ No
- ☐ Yes

Drinks per day
- ☐ Less than 1
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 or more

Risk factors for Colon Cancer (please check all appropriate boxes)

History
- ☐ Prior history polyp - adenoma or villous adenoma
- ☐ Prior history of Colon / Rectal cancer
- ☐ Father with colon cancer
- ☐ Mother with colon cancer
- ☐ Sibling with colon cancer
- ☐ Child with colon cancer
- ☐ Family history of colon polyps
- ☐ Chronic Ulcerative colitis

Last Colonoscopy
- ☐ Never
- ☐ 1 year
- ☐ 2 years
- ☐ 3 years
- ☐ 4 years
- ☐ 5 years
- ☐ 6 years
- ☐ 7 years
- ☐ 8 years
- ☐ 9 years
- ☐ 10 or more

Colonoscopy Results
- ☐ Normal
- ☐ Adenomatous polyp
- ☐ Hyperplastic polyp
- ☐ Villous adenomatous polyp
- ☐ Diverticulosis
- ☐ Cancer
- ☐ ____________________

Review of Systems: *Please check any recent symptoms you may have. If you do not have any please check none*

General:
- ☐ **None**
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Anorexia (loss of appetite)
- ☐ Fatigue
- ☐ Malaise
- ☐ Weight loss

Gastrointestinal:
- ☐ **None**
- ☐ Abdominal pain
- ☐ Anal / rectal pain
- ☐ Anal Itching
- ☐ Nausea
- ☐ Vomiting
- ☐ Change in bowel movments
- ☐ Constipation
- ☐ Diarrhea
- ☐ Rectal bleeding - hematochezia
- ☐ Melena - black tarry stool
- ☐ Gas / bloating
- ☐ Indigestion / heartburn
- ☐ Dysphagia - difficulty swallowing
- ☐ Odynophagia - painful swallowing

Breast:
- ☐ **None**
- ☐ Left breast lump
- ☐ Right breast lump
- ☐ Nipple discharge
- ☐ Bloody discharge from nipple
- ☐ Breast pain
- ☐ Abnormal mammogram
- ☐ Breast enlargement

Cardiovascular
- ☐ **None**
- ☐ Chest pain
- ☐ Palpitations
- ☐ Syncope - passing out
- ☐ Peripheral edema

Respiratory
- ☐ **None**
- ☐ Cough
- ☐ Shortness of breath
- ☐ Hemoptysis - coughing up blood
- ☐ Wheezing
- ☐ Pleuritic chest pain

Genitourinary - Female:
- ☐ **None**
- ☐ Vaginal discharge
- ☐ Incontinence
- ☐ Painful unrination - dysuria
- ☐ Blood in urine - hematuria
- ☐ Urinary frequency
- ☐ Abnormal vaginal bleeding
- ☐ Pelvic pain
- ☐ Pregnant

Genitourinary - Male
- ☐ **None**
- ☐ Painful urination - dysuria
- ☐ Blood in urine - hematuria
- ☐ Discharge
- ☐ Urinary frequency
- ☐ Urinary hesitancy
- ☐ Nocturia
- ☐ Incontinence
- ☐ Erectile dysfunction

Dermatology - Skin
- ☐ None
- ☐ Suspicious lesions
- ☐ New skin lesions
- ☐ Rash
- ☐ Itching
- ☐ History of skin cancer

Neurologic:
- ☐ **None**
- ☐ Paralysis
- ☐ Paresthesias - numbness
- ☐ Seizures
- ☐ Frequent headaches

Psychiatric:
- ☐ **None**
- ☐ Depression
- ☐ Anxiety
- ☐ Memory loss
- ☐ Suicidal ideation
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Phobia
- ☐ Confusion
- ☐ Emotional instability

Endocrine:
- ☐ **None**
- ☐ Heat / cold intolerance
- ☐ Polydipsia
- ☐ Polyphagia
- ☐ Polyuria

Hematology:
- ☐ **None**
- ☐ Abnormal bruising
- ☐ Bleeding
- ☐ Enlarged lymph nodes

Musculoskeltal:
- ☐ **None**
- ☐ Back Pain
- ☐ Sciatica
- ☐ Arthritis

Willamette Surgical Specialists, LLP
Dr. Chong Chang, Dr. Brent Evetts, Dr. Paul Klas & Dr. Patrick McBee

Notice of Your Right to Decline Participation in Future Anonymous or Coded Genetic Research

The State of Oregon has laws to protect the genetic privacy of individuals. These laws give you the right to decline to have your health information or biological samples used for research. A biological sample may include a blood sample, urine sample, or other materials collected from your body. You can decide whether to allow your health information or biological samples to be available for genetic research. Your decision will not affect the care you receive from your health care provider or your health insurance coverage.

Research is important because it gives us valuable information on how to improve health, such as ways to prevent or improve treatment for heart disease, diabetes, and cancer. Under Oregon law, a special team reviews all genetic research before it begins. This team makes sure that the benefits of the research are greater than any risks to participants.

In anonymous research, personal information that could be used to identify you, like your name or medical record number, cannot be linked to your health information or biological sample. In coded research, personal information that could be used to identify you is kept separate from your health information or biological sample so it would be very difficult for someone to link your personal information to your health information or biological sample. Your identity is protected in both types of research.

If you want to allow your health information and biological sample to be available for anonymous or coded genetic research, **you check the box below labeled 'I agree' & sign the form.** If you make this choice, your health information or biological sample may be used for anonymous or coded genetic research without further notice to you.

If you want to decline to have your health information and biological sample available for anonymous or coded genetic research, you must tell your health care provider by: **checking the box marked 'I decline' & sign the form. Your decision is effective on the date your health care provider receives this form.**

If you have any questions or concerns about this notice, please contact our Office Manager at 503-691-1743. You may also learn more about this new law at www.oregongenetics.org

No matter what you decide now, you can always change your mind later. If you change your mind, tell your health care provider your decision in writing. If you change your mind, the new decision will apply only to health information or biological samples collected **after your health care provider receives written notice of your new decision.**

☐ I agree to have my health information and biological samples available for anonymous or coded genetic research.

☐ I decline to have my health information and biological samples available for anonymous or coded genetic research.

Printed Name ____________________ Date of Birth ____________________

Signature ____________________ Date ____________________