



THE KINGSLEY CLINIC

ALEXANDER KINGSLEY, M.D., F.A.C.S.
1500 SOUTH 48TH ST, SUITE 709
LINCOLN, NE 68506
(402) 484-7600

Account # _____

Please PRINT Legibly

Date _____

Full Legal Name _____ Sex M F

Birth date _____ Age _____ Home Phone _____ Cell Phone _____

Social Security Number _____ Email _____

Home Address _____

City _____ State _____ Zip _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone _____

Retired: YES NO Previous Occupation (if retired) _____

Marital Status: Single Married Divorced Separated Widowed Other

Spouse's Name _____ Spouse's Date of Birth _____

Employer _____ Work Phone _____

Who may we contact in case of emergency (other than spouse):

Name _____ Home Phone _____ Work Phone _____

Address _____ Relationship to you _____

Name of your primary/family doctor _____

Who referred you to our office? _____ Thanks letter OK? Initials _____

What is your complaint? _____

<p>FOR WOMEN Number of deliveries _____ Number of miscarriages _____ Are you pregnant? YES NO</p> <p>Do you have difficulty with excessive or irregular periods or other female problems? _____</p> <hr/> <p>Date of LAST PERIOD _____ MENOPAUSE _____ DATE OF LAST DELIVERY _____</p> <p>C-SECTION: YES NO Are you currently taking birth control pills? YES NO</p> <p>Last Mammogram date: _____ Results: ____ Normal ____ Abnormal Location: _____</p> <p>Hysterectomy YES NO Ovaries removed? YES NO Have you ever taken Hormones? YES NO</p>
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Habits/Lifestyle: Exercise? YES NO How Often?: _____

Special Diet: YES NO Type _____

Coffee – cups/day _____ Tea – cups/day _____ Soda – per day _____

Alcoholic Drinks: Never Rare Frequent Now or Previously Type and Amount: _____

Do you **smoke**? YES NO Packs/day _____ For how long? _____ Date you stopped smoking _____

Have you ever taken **Chemotherapy**? YES NO Do you have any **sensitivities to latex**? YES NO UNKNOWN

Have you taken any **Steroids** within the last year? YES NO Explain _____

Have you or family ever had a **reaction to anesthesia**? YES NO UNKNOWN

Have you or family ever had **bleeding disorders**? YES NO UNKNOWN

Do you take any **blood thinners**; Coumadin, Plavix, Aspirin, Ibuprofen, Vitamin E or Arthritis medications? YES NO

If yes, list name, dose, and frequency _____

Do you take **laxatives** routinely? YES NO If yes, list name, dose, and frequency _____

Do you have any **artificial devices** implanted? (hips, knees, heart stents, pacemaker, etc.) YES NO

If yes, name the device _____

Do you have to take **antibiotics** before any procedure? YES NO UNKNOWN

What **medications** are you **allergic** to? _____

Ever had **blood transfusions**? YES NO Any reactions/complications? YES NO _____

Check all that apply and provide explanations below:

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Anemia | <input type="checkbox"/> Polio | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Black tarry stool | <input type="checkbox"/> Hernia | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Phobias | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Chest Pain / Angina | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Low blood sugar |
| <input type="checkbox"/> Rectal bleeding | <input type="checkbox"/> Cancer | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Stress | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Change in bowel habit | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Heart Disease/Murmur | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Stroke | <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Eczema / Rashes |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Indigestion/Bloating | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Colon Polyp | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Colon Tumor | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Cystocele | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal STD |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Recent Weight gain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Drug / Alcohol abuse |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Recent Weight loss | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Fecal Incontinence | <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> Nervous Disease | <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Other (explain) |
| <input type="checkbox"/> Gallbladder trouble | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Varicose Veins | |
| <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Headaches– <i>Frequent</i> | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Sensation changes | |

ADDITIONAL COMMENTS: _____

Medications: (Continue on back of form if necessary)

MEDICATION	DOSAGE	FOR CONDITION/DISEASE	NAME OF DOCTOR

Past Colon Exams:

PROCEDURE	DATE PREFORMED	DOCTOR	LOCATION	RESULTS
COLONOSCOPY				
FLEXIBLE SIGMOIDOCSCOPY				
BARIUM ENEMA				

Major Hospitalizations: (Continue on back of form if necessary)

OPERATION/ILLNESS	DATE	DOCTOR	LOCATION

FAMILY HISTORY	FATHER	MOTHER	CHILDREN	SIBLINGS	FATHER'S PARENTS	MOTHER'S PARENTS	OTHER DISEASE NOT LISTED
CANCER							
WHAT TYPE?							
HEART DISEASE							
KIDNEY DISEASE							
BLEEDING DISORDER							
DIABETES							

The information that I have supplied I believe is complete and true to the best of my knowledge:

Signature of Patient or Authorized Person Date

Witness Date



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(402) 484-7600 (402) 484-7660 FAX

SUMMARY NOTICE OF PRIVACY PRACTICES

Effective Date of Notice _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We use your information to provide medical treatment to you, to collect payment for our services, and conduct normal operations in our office.

There may be unusual situations that allow or require us to disclose your health information without your permission to legal authorities and agencies. A detailed list of those possibilities required by law is available to you upon request.

We may contact you to provide appointment reminders, provide treatment information and alternatives, or other health related benefits that may be of interest to you. We may discuss your health information with

Name	Relationship to Patient
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Please list your family members, relatives, personal representative or others involved with your care if you wish to approve this communication. Other uses and disclosure of your medical information will only be made with your written authorization, which you may later revoke.

You have specific rights to your medical information that include:

- Right to receive a copy of our detailed Notice of Privacy Practices, (available upon request).
- Right to request restrictions on use and disclosure of your information.
- Right to receive confidential communication of your protected health information.
- Right to inspect and copy your protected health information.
- Right to request amendment to your protected health information.
- Right to receive an accounting of protected health information disclosures.

There are specific forms to fill out if you want to exercise any of these rights. According to state law our office can charge a maximum fee of \$20.00 as a handling fee and up to \$0.50 per page as a copying fee for these records. You will be notified of the charge at the time of request. You may request the forms at the reception desk or by calling 402-484-7600 to talk to Jeanine who is our Privacy Officer.

I acknowledge that the detailed **NOTICE OF PRIVACY PRACTICES** of Consultants in Surgical Specialties, P.C. has been made available to me.

Signature of Patient or Authorized Person	Date
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PRINT Patient's Full Legal Name	Relationship to Patient
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Witness	Date
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