TOOTLA & ASSOCIATES, M.D., P.C.
PRACTICE LIMITED TO COLON AND RECTAL SURGERY

PATIENT INFORMATION

DATE: _____/_____/_____

BIRTHDATE: _____/_____/_____ AGE: ______ SEX: ______ MARITAL STATUS: S M D W

REFERRED BY: ______________________________ PRIMARY DR: ________________________

NAME: ____
(LAST) (FIRST) (MIDDLE)

ADDRESS: ____
(NO.) (STREET)

____
(CITY) (STATE) (ZIP + 4 DIGIT CODE)

TELEPHONE ( ) ---------------------------- CELL # ( )___________________________

EMPLOYER: ___________________________
(COMPANY NAME)

INSURANCE COMPANY NAME: _________________ POLICY #: ____________________

NAME OF SPOUSE/OR PARENT IF MINOR: ____

EMERGENCY CONTACT PERSON: ____

(NAME) (PHONE)

RELATION: _______________ RELEASE INFORMATION TO:_________________________________

PHARMACY INFORMATION: NAME: ______________________________________

LOCATION:____ PHONE (_____)___________________

YOUR EMAIL: __________________

RACE: ________________ LANGUAGE: ____________

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE: X ____

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NAME: ______________________________ **DATE:** ______________

HT:________ WT:________ BP:________ P:________

Main complaints: State reason for your visit:

____

____

Duration of Problem: ____

Rectal bleeding: yes_____ No_____ Any rectal pain with bowel movements? yes_____ no_____

Constipation: yes_____ no_____ Diarrhea: yes_____ no_____

Change in bowel habits: yes_____ no_____

Abdominal pain: yes_____ no_____ Describe abdominal pain: dull____ sharp____ cramping____

Nausea: yes_____ no_____ Vomiting: yes_____ no_____ Indigestion: yes_____ no_____

Weight loss: yes_____ no_____ Appetite loss: yes_____ no_____

Rectal discharge: yes_____ no_____ color:__________ Itching around anus: yes_____ no_____

Please circle

Smoking: yes_____ no______ never______ Packs per day:____________ How long:____________

Alcohol: yes____ no____ Daily____ Weekly____ Rarely____ Beer_____ Wine_____ Liquor_____

Red Meat: yes___ no____

Please list your medications & dosages: ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

Allergies:

______________ ______________ ______________

______________ ______________ ______________

SCREENING COLONOSCOPY? YES__ DATE DONE: ____________ NO__

LAST MAMMOGRAM? ________

COVID VACCINATED? YES___ NO____

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AUTHORIZATION TO TREAT

I, the undersigned hereby give authorization for myself and/or the minor under my care to be treated by: DR. TOOTLA. The signature will cover the treatment given today and the treatment for any future date of entrance to this office.

SIGNATURE: **X**____ Date:_______________
(Patient or Guardian, Nearest Relative)

ASSESMENT OF BENEFITS

I, **X**____ hereby authorize payment directly to the physician who provided services for which benefits are payable, but not to exceed the usual and customary charges. I also certify the information given by me, if applying for payment under, Title XV11 of the Social Security Act is correct. I assume responsibility for all charges declined by my insurance carrier. In the event I do not have insurance coverage, I assume responsibility for any and all charges incurred.

X____ Date: _______________
Signature of Policy Holder or Insured

NOTICE OF PRIVATE PRACTICES FOR

This notice describes how information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

I give permission for the following: **PLEASE INITIAL:**

_______ Release information to the insurance company and billing service for claim processing and payments.

_______ Leave a message on voicemail or an answering machine for appointment reminders and general information. NO test results would be left on message.

_______ Give the pharmacist pertinent information for calling in a prescription if needed.

_______ Release information to hospitals, physicians, health departments, laboratories. This is generally done for test or surgery that needs to be ordered or scheduled, and copies of test results that you would want sent to the referring Doctors.

I may revoke my consent in writing. If I do not sign this contract, Tootla & Associates, M.D., P.C. may decline to provide treatment.

Patient's Name: ____

Parent or Guardian's Name____

Signature: **X**____ Date: ________________

FAROUK S. TOOTLA, MD
TOOTLA & ASSOCIATES MD, PC

5220 HIGHLAND RD STE 200
WATERFORD, MI 48327
248-334-3197

You are scheduled for : Screening / Diagnostic is subject to your deductible

DATE: ______________________________ **Arrive:** _____ a.m./p.m.

Waterford Surgical Center / 248-886-5555
5220 Highland Rd. Ste. 100. Waterford, MI 48327

MIRALAX PREP:

Purchase over the counter: two 32oz bottles of Smart Water or Gatorade (any flavor BUT NO red or purple), one 235gram bottle of Miralax, and 4 Dulcolax tablets.

Stop taking blood thinners: 5 days before for Plavix, 3 days before for Coumadin and Warfarin, 2 days before for Xarelto and Eliquis Baby Aspirin is ok.
Diabetic Medication: Should be taken after procedure is done

Two days prior to colonoscopy: Take 2 Dulcolax tablets at bed time.

Clear liquid diet the DAY BEFORE that procedure. NO SOLID FOODS! You may have liquids such as apple juice, jello (no fruit added), bouillon/broth, black coffee, tea (no milk), water, white grape juice, ginger ale, 7-up, Vernors, Coke. NO RED OR PURPLE LIQUIDS AND NO DAIRY PRODUCTS.

Mix the entire container of Miralax and 64oz. of Smart water or Gatorade together in a large pitcher. Chill in the fridge until ready to drink

Directions:

- **2pm:** Take 2 Dulcolax tablets with water and continue clear liquids
- 5pm: Drink Half Container (32oz.) of Miralax mixture.
- **7PM:** Drink the REMAINDER of the Miralax mixture until it's gone.

STOP EATING AND DRINKING AFTER MIDNIGHT
You MAY take your blood pressure medications with a SIP of water the morning of the procedure.
Please leave all valuables/Jewelry at home.

*****You need to have a driver with you, who must remain in the waiting room during the exam.*****

A copy of your report will be sent by the Waterford Surgical Center to the Doctors that you request. The facility will call you the day before to confirm and your procedure time may be subject to change. Any deductibles/co-pays will be collected by the Waterford Surgical Center at the time of service. Dr. Tootla's charges/billing and the Waterford Surgical Center charges/billing are separate. **If you are having a screening colonoscopy and something is found, such as a polyp or lesion, the procedure will change to diagnostic colonoscopy and you will be subject to your deductible and copayment. If you are having any symptoms such as bleeding or bowel habit changes, this is not covered under screening.**

If you have any questions or concerns, please feel free to call our office or the Waterford Surgical Center.

WHAT IS A COLONOSCOPY? Colonoscopy is an effective procedure to diagnose abnormalities of the large intestine and to screen for colorectal cancer and colorectal polyps. A colonoscope is a long, flexible instrument that provides magnified views of the colon and rectum. The procedure is frequently performed in an outpatient setting with minimal discomfort and inconvenience. Because colonoscopy allows doctors to identify and remove certain types of colon polyps that may develop into cancer, colonoscopy can be a therapeutic and even life-saving procedure.

WHY DO I NEED THIS TEST?

1.) Bleeding which cannot be explained by examining the lower end of the colon or rectum.
2.) Your colon x-ray, also called a barium enema or CT abdomen showed a growth or a possibility of a growth such as a polyp or cancer.
3.) You have had a past history of colon cancer or polyps.
4.) You have a family history of colon cancer or polyps
5.) You have had a stool test which showed evidence of blood which could not be seen with the naked eye.
6.) You have unexplained anemia, or unexplained weight loss.
7.) You have recently noted a change in bowel habits.
8.) You have or have had a history of colitis.
9.) You have abdominal pains which your own doctor or we cannot explain by doing all other exams.
10.) **Screening for patients 45 years and older**

WILL I BE ASLEEP FOR THIS TEST? Yes. Anesthesia is administered by the Anesthesiologist. **You must not eat or drink anything after midnight prior to your procedure.**

DO I NEED TO BRING SOMEONE WITH ME? YES. You must bring a member of your family or a friend with you to drive you home. Because of the sedation you are not allowed to drive yourself home.

WHAT ARE THE COMPLICATIONS OF THIS TEST? There is some risk to this procedure, as with any procedure. This includes bleeding, perforation, and other complications associated with any procedure. However, this risk is minimal.

HOW SOON WILL I GET A REPORT ON MY EXAM? We usually like to explain to the patient as to what is happening while we are doing the test, but most patients are too drowsy to understand. So at the end of the exam we will come out to the waiting area and explain to your family member or your friend what we found and what was done. When we remove a growth or do a biopsy we send the specimen to the hospital pathologist. For the pathologist to prepare and analyze the growth or biopsy it takes anywhere from 4 to 6 days. We prefer you to call the office within 24 hours to make a follow-up appointment, so we have the opportunity to discuss the findings with you and any type of follow-up that you may require for the future. If you have any questions or concerns about this procedure after you have read this information please feel free to call us so that we can explain anything you don't understand. We always feel that we should take care of our patients in the same manner and respect that we would want to be taken care of. You give us the privilege to take care of your body and we will do the best we know how. **A copy of your report will be sent by the facility to the Doctors that you request.**