

Advanced Care Centers New Patient Sheet

Date: _____
Time: _____

Patient Name _____ Address _____
Phone # (H) _____ City _____
Alternate # _____ State _____ Zip Code _____
Date of Birth _____ Email _____

Male or Female (circle one)

PATIENT INFORMATION

- 1) How did you here about our center? _____
- 2) How long would you say you've been suffering with hemorrhoids? _____ yrs./mo.
- 3) Most of our patients describe symptoms such as bleeding, itching, pain, and protrusion (circle all that apply).
- 4) What have you tried to help with those symptoms? Preparation H, Suppositories, Increased fiber, Anusol, Proctofoam, Increased fluids, over the counter meds, increased exercise (circle all that apply)
- 5) Are you taking any blood thinners? _____

INSURANCE INFORMATION

Primary Insurer's Name/Relation _____
Primary Insurer's Employer _____
Insurance Company's Name _____
Member Identification # _____
Insured's Group # _____
Insurance Company's Phone # _____
Provider /Benefits Inquiry _____

Advanced Care Centers 703 Green Rd. Suite 1, Madison IN 47250
Phone # (800) 863-9980 Fax # (812) 265-9998

Please return to our office by mail or fax and a patient coordinator will call to confirm insurance benefits and schedule your first appointment as soon as possible.