



NEW PATIENT REGISTRATION & INTAKE FORM

Mantilla Surgical Colorectal & Pelvic Health

Nathalie Mantilla, MD, MPH, FACS, FASCRS

Please complete this packet before your first visit. Bring your photo ID, insurance cards, medication list, relevant records, and any prior colonoscopy/pathology reports available to you.

If a question does not apply, write N/A. Please do not leave medication or allergy sections blank.

Patient Name	
Date of Birth	
Appointment Date / Time	
Preferred Name	

Please complete this form before your first visit. Bring your photo ID, insurance card(s), current medication list, and any relevant outside records or test results.

FOR PRACTICE USE

MRN	
Referral Received	☐ Yes ☐ No
Records Received	☐ Yes ☐ No
NPP Acknowledgment	☐ Signed ☐ Declined / Unable

1. Patient Registration & Demographics

Please use the patient's legal name for insurance and billing.

Legal Name	First	Last
Preferred Name		
Date of Birth	Sex listed on insurance: ☐ Female ☐ Male ☐ Other/Unknown	
Age		
Sex listed on insurance	☐ Female ☐ Male ☐ Other/Unknown	
Pronouns (optional)		
Address		
City / State / ZIP		
Mobile Phone	☐ May leave voicemail	
Home / Other Phone	☐ May leave voicemail	
Email		
Preferred Contact	☐ Phone ☐ Text ☐ Email ☐ Patient portal (CharmEHR)	
Preferred Language	Interpreter needed? ☐ Yes ☐ No	
Marital Status	☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Other	
Occupation / Employer		

Emergency Contact

Name	
Relationship	
Phone	

Primary Care & Referring Clinicians

Primary Care Clinician	Name	Phone
Referring Clinician	Name	Phone
Preferred Pharmacy	Name	Phone
Pharmacy Location		

2. Insurance, Guarantor & Billing Information

Primary Insurance	Plan
Member / Policy ID	
Group #	
Subscriber Name	
Subscriber DOB	
Relationship to Patient	☐ Self ☐ Spouse ☐ Parent ☐ Other
Secondary Insurance	Plan
Member / Policy ID	
Group #	

Guarantor / Responsible Party

Name	
Relationship	
DOB	
Address (if different)	
Phone / Email	

Insurance reminder: Insurance coverage is a contract between you and your health plan. Verification of benefits is not a guarantee of payment. Please notify the practice promptly of changes to insurance information.

3. Reason for Visit & Colorectal / Pelvic Health History

Primary reason for today's visit: _____

When did this problem begin? _____

- ☐ Rectal bleeding ☐ Hemorrhoids ☐ Anal pain ☐ Anal fissure ☐ Abscess / fistula ☐ Itching / irritation
☐ Constipation ☐ Diarrhea ☐ Change in bowel habits ☐ Fecal urgency ☐ Fecal incontinence / leakage
☐ Difficulty emptying ☐ Rectal prolapse / bulge ☐ Pelvic pressure ☐ Abdominal pain ☐ Bloating
☐ Colon / rectal cancer ☐ Colon polyps ☐ Inflammatory bowel disease ☐ Diverticulitis ☐ Ostomy care
☐ Pelvic floor dysfunction ☐ Other: _____

Bowel Function

Bowel movements	_____ per day / _____ per week
Typical stool consistency	☐ Hard/pellets ☐ Formed ☐ Soft ☐ Loose/watery ☐ Varies
Straining	☐ Never ☐ Sometimes ☐ Often ☐ Always
Incomplete emptying	☐ Never ☐ Sometimes ☐ Often ☐ Always
Need to splint / press	☐ No ☐ Yes - vaginal/perineal/other: _____
Urgency	☐ No ☐ Yes
Accidental stool leakage	☐ No ☐ Yes Frequency: _____
Accidental gas leakage	☐ No ☐ Yes
Pads / protective garments	☐ No ☐ Yes How many/day? _____
Rectal bleeding	☐ No ☐ Yes ☐ Bright red ☐ Dark/maroon ☐ Unsure
Rectal/anal pain	☐ No ☐ Yes Severity 0-10: _____
Prolapse / tissue protrusion	☐ No ☐ Yes ☐ Reduces itself ☐ I push it back ☐ Stays out

Prior Testing / Treatment

- ☐ Fiber ☐ Laxatives ☐ Stool softeners ☐ Antidiarrheals ☐ Pelvic floor physical therapy ☐ Biofeedback
☐ Hemorrhoid banding ☐ Hemorrhoid surgery ☐ Fistula/abscess surgery ☐ Rectal prolapse surgery ☐ Other: _____

4. Medical History

Check all that apply. Add details where requested.

- ☐ High blood pressure ☐ Heart disease / coronary artery disease ☐ Heart failure
☐ Irregular heartbeat / atrial fibrillation ☐ Stroke / TIA ☐ Blood clot / DVT / PE
☐ Bleeding disorder ☐ Diabetes ☐ Kidney disease
☐ Liver disease / cirrhosis ☐ Lung disease / COPD / asthma ☐ Sleep apnea / CPAP
☐ Seizure disorder ☐ Thyroid disease ☐ GERD / reflux
☐ Inflammatory bowel disease (Crohn's / UC) ☐ Diverticulitis ☐ Colon polyps
☐ Colon or rectal cancer ☐ Other cancer ☐ Anemia
☐ Immune disorder / immunosuppression ☐ Anxiety / depression ☐ Other: _____

Please explain important conditions, dates, or current specialists: _____

Cancer History

Type of cancer	
Year diagnosed	
Treatment	☐ Surgery ☐ Chemotherapy ☐ Radiation ☐ Other _____
Current oncologist	

Anesthesia / Bleeding / Clotting

- ☐ Prior anesthesia complication ☐ Difficult airway/intubation ☐ Severe nausea/vomiting after anesthesia ☐ Malignant hyperthermia (self/family)
☐ Easy bruising/bleeding ☐ History of blood transfusion ☐ History of DVT/PE ☐ None of the above

Details: _____

5. Surgical & Procedural History

Procedure / Surgery	Year	Hospital / Surgeon	Complications?

Colonoscopy / Endoscopy History

Have you had a colonoscopy?	☐ No ☐ Yes Most recent year:
Where / by whom?	
Polyps found?	☐ No ☐ Yes ☐ Unsure
Pathology / diagnosis	
Recommended interval	
Prior flexible sigmoidoscopy / EGD	☐ No ☐ Yes Details:

Implanted Devices / Ostomy

☐ Pacemaker/ICD ☐ Sacral nerve stimulator ☐ Other neurostimulator ☐ Insulin pump/CGM ☐ Vascular port ☐ Ostomy

Device / ostomy details: _____

6. Medications, Supplements & Allergies

Include prescription medicines, over-the-counter medicines, vitamins, herbs, injections, and patches.

Medication / Supplement	Dose	How Often	Reason

Please specifically identify if you take any of the following:

- ☐ Aspirin ☐ Clopidogrel (Plavix) ☐ Warfarin (Coumadin) ☐ Apixaban (Eliquis) ☐ Rivaroxaban (Xarelto)
☐ Dabigatran (Pradaxa) ☐ Enoxaparin (Lovenox) ☐ Insulin ☐ GLP-1 medication (e.g., semaglutide/tirzepatide) ☐ None

Allergies / Adverse Reactions

- ☐ No known drug allergies (NKDA) ☐ Latex allergy ☐ Adhesive allergy

Medication / Substance	Reaction

7. Family & Social History

Family History

- ☐ Colon cancer ☐ Rectal cancer ☐ Colon polyps ☐ Crohn's disease ☐ Ulcerative colitis ☐ Ovarian cancer
☐ Endometrial/uterine cancer ☐ Stomach cancer ☐ Pancreatic cancer ☐ Other hereditary cancer syndrome ☐ None known

Relative / diagnosis / age	
Relative / diagnosis / age	
Relative / diagnosis / age	

Social History

Tobacco	☐ Never ☐ Former ☐ Current Type/amount:
If former, quit year	
Alcohol	☐ None ☐ Occasional ☐ Weekly ☐ Daily Drinks/week:
Recreational substances	☐ No ☐ Yes Type/frequency:
Living situation	☐ Alone ☐ Spouse/partner ☐ Family ☐ Other
Need help with daily activities?	☐ No ☐ Yes Explain:

8. Pelvic, Obstetric & Gynecologic History (if applicable)

Complete only what is relevant to your care.

Number of pregnancies	
Vaginal deliveries	
Cesarean deliveries	
Largest baby weight	_____ lb _____ oz
Forceps / vacuum delivery	☐ No ☐ Yes
Severe perineal tear (3rd/4th degree)	☐ No ☐ Yes ☐ Unsure
Episiotomy	☐ No ☐ Yes ☐ Unsure
Hysterectomy	☐ No ☐ Yes Year: _____
Other pelvic surgery	☐ No ☐ Yes Details: _____
Pelvic organ prolapse	☐ No ☐ Yes ☐ Unsure
Urinary leakage / urgency	☐ No ☐ Yes
Menopausal	☐ No ☐ Yes ☐ Unsure / N/A

Brief Review of Systems

- ☐ Unintentional weight loss ☐ Fever/chills ☐ Fatigue ☐ Chest pain ☐ Shortness of breath
☐ Nausea/vomiting ☐ Abdominal pain ☐ Blood in stool ☐ Black stool ☐ Urinary symptoms
☐ New weakness/numbness ☐ Easy bleeding/bruising ☐ Other: _____

Anything else you want Dr. Mantilla to know? _____