

THE CENTER FOR COLON AND DIGESTIVE DISEASE

Michael W. Brown, MD Rajesh Patel, MD Dino Ferrante, MD C. Julian Billings, MD
John-Paul Voelkel, MD Meredith Roath, MD Mark Moglowsky, MD

Phone: 256-533-6488 • Fax: 256-533-6495

119 Longwood Drive SW
Huntsville, AL 35801

2007 Gallatin Street SW
Huntsville, AL 35801

460 Lanier Road, Suite 201
Madison, AL 35758

Patient Registration

PLEASE COMPLETE (print, write, type, check, and/or select)

Full Name: _____ Date of Birth: _____

Social Security #: _____ Sex: Male Female

Marital Status: Single Married Legally Separated Divorced Widowed

Language: (Please give preferred Language) _____

The following categories are required for compliance with U.S. Government regulations.

Race:	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black	<input type="checkbox"/> African American
	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> White	
	<input type="checkbox"/> Multicultural	<input type="checkbox"/> Refuse to Report	<input type="checkbox"/> Unknown	
Ethnicity:	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Non-Hispanic/Non-Latino	<input type="checkbox"/> Decline	<input type="checkbox"/> Unknown

Street Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Employer: _____ May we call you at work? Yes No

Self-Employed? Yes No If Self Employed, Name of Business: _____

Occupation: _____ How Long Employed? _____ Full-time Part-time

Employer's Address: _____

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

Spouse's Social Security #: _____ Spouse's Employer: _____

Spouse's Occupation: _____ May we call them at work if necessary? Yes No

Spouse's Work Phone: _____ Spouse's Cell Phone: _____

In Case of an Emergency, Notify: _____ Relationship: _____ Phone: _____

Who Referred You to This Office? _____ Who is your Family Physician? _____

Have You Seen Any of Our Physicians Before? Yes No If Yes, Whom? _____

Do you have Medical Coverage? Yes No Primary Insurance Company: _____
 I.D. #: _____ Group #: _____
 Subscriber's Name: _____ Relationship to Patient: _____
 Secondary Insurance Company: _____ I.D. # _____ Group #: _____
 Subscriber's Name: _____ Relationship to Patient: _____

If Responsible Party is Other than the Patient, Please Complete The following:

Responsible Party Name: _____		Relationship: _____	
Address: _____		City: _____	State: _____ Zip: _____
Date of Birth: _____		Social Security #: _____	
Employer: _____		<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
Home Phone: _____		Cell phone: _____	Work Phone: _____
Email Address: _____			

In order to provide our patients with the highest level of care, any procedure cancellation with less than 48 hour notice may result in a \$75.00 cancellation fee. This cancellation fee is not covered by your insurance. Payment of this fee will be required prior to rescheduling the missed procedure. There will be a \$10.00 administration service charge for filling out any Prior Authorization (P.A.) forms that your insurance company may require in order for you to obtain their approval for prescription medication. This fee must be paid prior to the completion of your P.A. form. There is also a \$15.00 administration fee if you have to be invoiced for your co-pay.

AUTHORIZATION & ASSIGNMENT: Please Read and Sign the Following Statement:

I directly assign all medical/ surgical benefits to The Center for Colon and Digestive Disease/ Huntsville Endoscopy Center and understand that I am financially responsible for all charges not covered by my insurance. I hereby authorize the Physician/ Practice to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE:

In the event that it becomes necessary to collect any amounts owed by you, you agree that The Center for Colon and Digestive Disease, PC. and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial messages and/or use of automatic dialing device, as applicable.

It is customary that payment be made when the service is rendered unless prior arrangements have been made in advance. In the event of non-payment, either by insurance or myself, I agree to pay all cost of collection, including a reasonable attorney's fee in the event it is necessary to employ an attorney to enforce any provision of this contract.

I hereby authorize any physician or hospital to provide copies of my medical history and treatment to The Center for Colon and Digestive Disease, P.C. Photocopies of this agreement are as good as the original. I have read this entire Patient Registration form and agree to all provisions of this form, including but not limited to the Authorization and Assignment provisions and the Consent to Contact provisions.

Signature: X _____ Date: X _____

Patient Name:

DOB:

Date of Visit:

If a physician or other healthcare provider referred you for today's visit, please indicate their name on the line below:

Reason for today's visit:

Location:

Severity (Scale 1-10)

Duration (how long)

Timing (when it occurs)

YOUR CURRENT SYMPTOMS

Please check the appropriate box(es) for any symptoms you are experiencing now.

General

- Fainting
- Dizziness
- Fever
- Weakness
- Feeling tired

Skin

- Itching Skin
- Rash on Skin

Head, Ears, Eyes, Nose & Throat

- Blurry vision
- Worsening vision
- Ringing in the ears
- Loss of hearing
- Hoarseness
- Sore throat

Respiratory

- Cough
- Bloody sputum
- Difficulty breathing
- Wheezing

Cardiovascular

- Chest pain or discomfort
- Irregular heartbeat
- Leg pain when walking
- Swelling of extremities

Digestive Tract

- Abdominal pain
- Nausea
- Vomiting
- Vomiting blood or coffee grounds
- Bloating or swelling
- Excess or foul belching
- Passing excess or foul gas
- Constipation
- Diarrhea
- Bloody or tar-like stool
- Leakage of stool or mucous from anus
- Anal or rectal pain
- Difficult or painful swallowing
- Heartburn
- Loss of appetite
- Weight loss of pounds
- Weight gain of pounds
- Jaundice (yellow skin or eyes)

Urinary Tract

- Blood in urine
- Burning upon urination
- Urinating frequently
- Delay/difficulty urinating
- Urgent need to urinate
- Loss of control of urination

Musculoskeletal

- Back pain
- Joint pain
- Muscle pain

Neurological

- Headaches
- Numbness
- Localized muscle weakness
- Confusion
- Excessive drowsiness

Psychiatric

- Anxiety
- Disorientation
- Depression
- Sleep disturbance
- Memory loss

Endocrine

- Cold intolerance
- Excessive thirst
- Heat intolerance
- Excessive urination

Hematology

- Easy bruising
- Enlarged lymph nodes

Male Conditions

- Prostate problems
- Impotence

Female Conditions

- Menstrual problems
- Abnormal vaginal bleeding
- Menopausal symptoms
- Breast lumps
- Breast discharge

None of the above

Immunizations: Flu Shot

- Yes
- No

Patient Name:

DOB:

Date of Visit:

YOUR PERSONAL MEDICAL HISTORY

Please check the appropriate box(es) for your past or ongoing medical conditions.

- | | |
|--|--|
| Allergic rhinitis | High blood pressure or hypertension |
| Anal warts | High cholesterol |
| Anticoagulation (blood thinner therapy) | HIV (human immunodeficiency virus) |
| Anxiety/depression | Home oxygen |
| Asthma | Hyperthyroidism |
| Barrett's esophagus | Hypothyroidism |
| Bleeding disorder | Inguinal hernia |
| Blood clots (location in body) | Insulin therapy |
| Breast cancer | Iron deficiency anemia |
| Celiac disease or sprue | Irritable bowel syndrome |
| Chronic renal failure syndrome | Ischemic colitis |
| Colon cancer | Kidney stones |
| Colon polyps | Lactose intolerance |
| Congestive heart failure | Liver cancer |
| COPD (chronic obstructive pulmonary disease) | Lung cancer |
| Coronary artery disease | Lymphoma |
| Coronary artery stent placement | Migraine headaches |
| Crohn's disease | Osteoarthritis |
| Diabetes mellitus | Osteoporosis |
| Dialysis (peritoneal or hemodialysis) | Osteopenia |
| Diverticulosis | Pancreatitis |
| Diverticulitis (infected diverticulosis) | Pancreatic cancer |
| Elevated triglycerides | Pernicious anemia |
| Emphysema | Personal history of bowel obstruction |
| Esophageal cancer | Prostate cancer |
| Esophageal reflux disease (GERD) | Prostate enlargement |
| Esophageal stricture | Radiation therapy for prostate cancer |
| Esophageal varices | Rheumatoid arthritis |
| Fatty liver | Schizophrenia |
| Fibromyalgia | Seizure disorder |
| Gallbladder stones or disease | Sinusitis |
| Gastritis | Sleep apnea (do you require C-PAP) |
| Genital herpes | Stomach or duodenal ulcer |
| Glaucoma | Stroke (cerebrovascular accident) |
| Gout | TB (tuberculosis) |
| Grave's disease | TIA (transient ischemic attack) |
| Hemorrhoids | Transfusion of blood or blood products |
| Hepatitis (type, if known) | Ulcerative colitis |
| Hiatal hernia | Valvular heart disease |
| History of Helicobacter pylori infection | <u>None of the above</u> |

SOCIAL HISTORY

Please check the appropriate box(es) for your social history that applies.

- | | |
|--|--|
| Tobacco: | Alcohol: |
| Cigarettes: Day | Type: |
| Cigars: Day | Amount: |
| Snuff: Day | Years: |
| Chew: Day | Never consumed: |
| Recently quit | Use of Recreational Drugs or Substances (name of substance |
| Never smoked | or drug): |

FAMILY HISTORY

Please check the appropriate box(es) for any important medical disorders that could be inherited from your close family member relationships (such as father, mother, sister or brother).

Please list family member:

- | | |
|--------------------|--------------------------|
| Heart disease | Ulcerative colitis |
| Hepatitis | Crohn's disease |
| Bleeding disorder | Colon cancer |
| Pancreatic disease | Other |
| Colon polyps | <u>None of the above</u> |

Patient Name: _____ DOB: _____ Date: _____

Surgeries

Please check the appropriate box(es) for any surgeries you have had in the past.

Gastrointestinal

- Appendectomy (removal of appendix)
- Cholecystectomy (removal of gallbladder)
- Colectomy or colon resection (removal of all or part of the colon)
- Exploratory abdominal surgery for adhesions
- Fundoplication (repair of hiatal hernia)
- Gastric bypass (weight loss surgery)
- Gastrectomy or gastric resection (removal of all or part of the stomach)
- Hemorrhoidectomy
- Inguinal (groin) hernia repair
- Splenectomy
- Ventral or abdominal wall hernia repair
- Whipple procedure for pancreatic cancer

Cardiac

- Abdominal aortic aneurysm repair
- Coronary artery bypass graft
- Femoral bypass
- Coronary artery stent placement
- Heart valve surgery
- Pacemaker placement
- Cardiac ablation for rhythm disturbance
- ICD device

Transplantation

- Liver transplant
- Kidney transplant

Genitourinary

- TURP (reduction of prostate gland through the penis)
- Cystectomy with ileal conduit
- Nephrectomy (removal of kidney)
- Prostatectomy (removal of prostate gland through the abdominal wall)
- Gold seed implant for prostate cancer

Gynecological

- Abdominal hysterectomy (removal of uterus through the abdominal wall)
- Vaginal hysterectomy (removal of uterus through the vagina)
- Oophorectomy (removal of ovaries)
- Cesarean delivery
- Breast biopsy

Other

- Breast augmentation
- Breast reduction, both
- Cataract surgery
- Glaucoma surgery
- Mastectomy (side _____)
- Skin lesion, local excision
- Thyroidectomy (removal of thyroid gland)
- Port-A-Cath placement

None of the above

GASTROINTESTINAL PROCEDURES

Please check the appropriate box(es) for any procedures you have had in the past.

- Colonoscopy Findings: _____ Year: _____
- Gastroscopy Findings: _____ Year: _____
- Liver biopsy Findings: _____ Year: _____
- ERCP Findings: _____ Year: _____

- None of the above

Patient Name: _____ DOB: _____ Date: _____
Pharmacy Information: _____

Medication List

PLEASE LIST ALL MEDICATIONS YOU TAKE and ANY KNOWN DRUG ALLERGIES by TYPING or SELECTING YOUR ANSWER. THEN PRINT and BRING TO OUR OFFICE.

I am currently on NO medications.

<u>Medication Name</u>	<u>Strength</u>	<u>Dosage</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have NO known drug allergies.

I HAVE THE FOLLOWING DRUG ALLERGIES:

THE CENTER FOR COLON AND DIGESTIVE DISEASE

Michael W. Brown, MD Rajesh Patel, MD Dino Ferrante, MD C. Julian Billings, MD
John-Paul Voelkel, MD Meredith Roath, MD Mark Moglowsky, MD

Phone: 256-533-6488

Fax: 256-533-6495

119 Longwood Drive SW
Huntsville, AL 35801

2007 Gallatin Street SW
Huntsville, AL 35801

460 Lanier Road, Suite 201
Madison, AL 35758

Authorization to Release Medical Records/Information

Physician to provide records: _____

Patient's Name: _____

Social Security # _____ DOB: _____

Person/Facility to receive records: _____

Address: _____

City, State, Zip: _____

Release these records:

Initials

1. Only records generated by this facility (not including records received from other sources) _____
2. Only some portion of records maintained at facility (dates of treatment, etc., specify below) _____
3. All medical records at this facility _____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the health care provider to release the information specified to the organization, agency or individual named on this request with the EXCEPTION OF:

Initials

_____ Substance abuse, if any

_____ Psychological or psychiatric conditions, if any

Initials

_____ AID/HIV, if any

Other (Please specify) _____

Expiration or revocation of authorization - I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.

Use of copies – A copy of this authorization may be utilized with the same effectiveness as an original.

Patient Name (print):

Person authorized to sign for patient:

Patient Signature

Signature

Date: ____/____/____

Date: ____/____/____