

# THE CENTER FOR COLON AND DIGESTIVE DISEASE

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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: \_\_\_\_\_

## 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





# **THE CENTER FOR COLON AND DIGESTIVE DISEASE**

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## **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: \_\_\_\_\_

### **Records to release (enter your initials):**

#### **Initials**

#### **Records:**

- \_\_\_\_\_ All medical records at this facility  
\_\_\_\_\_ Only records generated by this facility (not including records received from other sources)  
\_\_\_\_\_ Only some portion of records maintained at facility (dates of treatment, etc., please specify)

**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  
\_\_\_\_\_ AIDS/HIV, if any  
\_\_\_\_\_ Psychological or psychiatric conditions, 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 (print):**

\_\_\_\_\_

\_\_\_\_\_

**Patient Signature**

**Signature**

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_