# HUNTSVILLE ENDOSCOPY CENTER

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

119 Longwood Drive SW
Huntsville, AL 35801

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

**PLEASE PRINT** **PATIENT REGISTRATION** **Social Security #**_____

Full Name: _____ **Date of Birth:** _____ Age: _____

Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

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

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

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

Employer: _____ May We Call You at Work? ☐ Yes ☐ No

Occupation: _____ Are You Self-Employed? _____ If Self – Name of Business: _____

Employer's Address: _____ How Long Employed? _____ ☐ Full Time ☐ Part Time

Are You a Student? _____ ☐ Full Time ☐ Part Time

**Name of Spouse:** _____ Social Security # _____ Date of Birth: _____

Spouse's Employer : _____ Occupation: _____

**In Case of Emergency, Notify:** _____ Relationship: _____

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

**Have You Seen Any of Our Doctors Before?** ☐ Yes ☐ No If Yes, Whom? _____

**Do You Have Medical Insurance 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 YES, Please Give ALL of Your Cards to the Receptionist, Along With Any Completed Insurance Forms.**

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

I directly assign all medical/surgical benefits to Huntsville Endoscopy Center and understand that I am financially responsible for all charges not covered by my insurance. I hereby authorize the doctor 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.

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 my insurance or myself, I agree to pay all costs 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/We further agree to waiver my/our rights of exemption under the laws of the State of Alabama or of any other state.

**Signature: X** _____ **Date: X** _____

# HUNTSVILLE ENDOSCOPY CENTER
## History & Physical

| Patient Name | Age | DOB | Date |
|---|---|---|---|

**Check all conditions that apply to patient only.**

### AIRWAY/COMPLICATIONS WITH SEDATION/ANESTHESIA

- ❑ Difficult Intubation (Breathing Tube Insertion)
- ❑ TMJ/Limited Mouth Opening
- ❑ Missing/Loose teeth
- ❑ Extreme Nausea/Vomiting
- ❑ Dentures/Partials
- ❑ Awareness During Procedure
- ❑ Difficulty Waking Up
- ❑ Other _____

### CARDIAC/CARDIOLOGIST: _____

- ❑ HTN (High Blood Pressure)
- ❑ Chest Pain
- ❑ High Cholesterol
- ❑ Heart Disease/Abnormalities *If yes, explain below:
  * _____
- ❑ Irregular Heart Rhythm *If yes, explain below:
  * _____
- ❑ Heart Attack/MI If yes, date: _____
- ❑ Pacemaker/Defibrillator
- ❑ Heart Stent Placement If yes, date: _____
- ❑ Aneurysm
- ❑ Other _____

### PULMONARY

- ❑ Recent Cold/Respiratory Infection/Fever
- ❑ Chronic Cough
- ❑ Home Oxygen ($O^2$)
- ❑ Asthma/Wheezing If yes, use inhaler? _____
- ❑ SOB/Shortness of Breath
- ❑ COPD/Emphysema
- ❑ Sleep Apnea/Snoring If yes, use CPAP? _____
- ❑ Steroid Use Within Last 6 Months
- ❑ CHF (Congestive Heart Failure)
- ❑ Tuberculosis If yes, date: _____
- ❑ Other _____

### GASTROINTESTINAL

- ❑ GERD (Reflux)
- ❑ Heartburn
- ❑ Ulcerative Colitis
- ❑ Abdominal Pain
- ❑ Crohn's Disease
- ❑ Diarrhea
- ❑ IBS (Spastic Colon)
- ❑ Constipation
- ❑ History of Colon Polyps
- ❑ Appetite Loss
- ❑ Cirrhosis
- ❑ Weight Loss
- ❑ Celiac Disease
- ❑ Blood in Stool
- ❑ Barrett's Esophagus
- ❑ Vomiting Blood
- ❑ Nausea/Vomiting
- ❑ Rectal Pain
- ❑ Liver Disease/Hepatitis ❍ A ❍ B ❍ C
- ❑ Dysphagia/Difficulty Swallowing
- ❑ Other _____

### NEURO

- ❑ Seizures *If yes, explain below:
  * _____
- ❑ Paralysis
- ❑ Neuropathy
- ❑ Stroke/TIA
- ❑ Migraines
- ❑ Parkinson's/Tremors
- ❑ Dementia/Alzheimer's
- ❑ Mental Disability/Intellectual Disability
- ❑ Other _____

### RENAL

- ❑ Kidney Disease
- ❑ Edema/Fluid Retention
- ❑ Dialysis
- ❑ Prostate Enlargement
- ❑ Other _____

### ENDOCRINE

- ❑ Diabetes ❍ IDDM/Insulin ❍ NIDDM/Non-Insulin
- ❑ Thyroid Disease
- ❑ Pancreatic Disease
- ❑ Other _____

### MUSCULOSKELETAL

- ❑ Arthritis ❍ Osteoarthritis ❍ Rheumatoid Arthritis
- ❑ Multiple Sclerosis
- ❑ Fibromyalgia
- ❑ Chronic Back/Neck Pain
- ❑ Gout
- ❑ Other _____

### OTHER

- ❑ CANCER of ❍ Colon ❍ Other
- ❑ Bleeding Disorder *If yes, explain below:
  * _____
- ❑ Anemia
- ❑ HIV/AIDS
- ❑ Other Infectious Disease _____
- ❑ SKIN: ❑ Open Wounds ❑ Lesions ❑ Burns ❑ Bruising
  If yes, location: _____
- ❑ Other _____

### PSYCHIATRIC

- ❑ Anxiety/Depression
- ❑ ADD/ADHD
- ❑ Mental Disorder *If yes, explain below:
  * _____

### SOCIAL HISTORY

- ❑ Cigarettes _____packs per _____day_____ years
- ❑ Other Tobacco Use _____
- ❑ Alcohol If yes, how much/often? _____
- ❑ Drugs ❑ Marijuana ❑ Cocaine ❑ Meth
- ❑ Other _____

**Patient Name**

**PROCEDURE**: ❍ Colonoscopy ❍ Esophagogastroduodenoscopy ❍ Flexible Sigmoidoscopy ❍ Other

**Reason for Today's Procedure/Symptom:** _____

_____

_____

**ALLERGIES/REACTIONS**

_____

_____

_____

_____

**PREVIOUS SURGERIES**

_____

_____

_____

_____

_____

_____

_____

**MEDICATIONS**

**List all PRESCRIBED and OVER-THE-COUNTER Medications**

❑ **Check here if list was provided TODAY by patient.**

**If no list provided, please complete below.**

| MEDICATIONS | DOSAGE | LAST DOSE |
|---|---|---|
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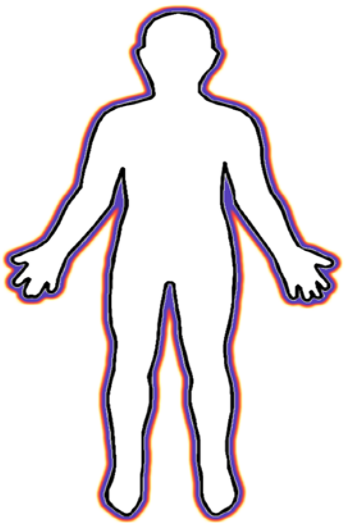
**Indicate Location of Any METAL**

❑ **NONE**

**Right** **Left**



**Advanced Directive (for Healthcare)** ❍ **YES** ❍ **NO**

**If yes, copy on chart** ❍ **YES** ❍ **NO**

**Patient Label**

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## Valuables / Responsible Driver Form

Huntsville Endoscopy Center is not responsible for any valuables that are brought into the department. We request that you leave all valuables at home. If this is not possible, they should be left with the patient's responsible adult. If items can not be left with your driver let the admitting nurse know. Glasses and dentures may remain with patient through out stay at Huntsville Endoscopy Center. You are required to remove jewelry. If something is not removable, tell the nurse when you are admitted. Please bring only necessary items into the department. We have space for wheelchairs, walker, canes, etc.

I understand the above statement.

_____ _____

Signature Date

In your best interest, we ask that you responsible driver remain on the premises during you stay.
If you are sedated, you will not be able to operate any machinery, drive a vehicle, or return to work today.

We also prefer to discuss the results of your test today in recovery with the person you have designated to receive this information. Please complete this permission form so we can do this, otherwise, check the area that indicates results are to be given only to you.

☐ I give Huntsville Endoscopy Center staff and my physician permission to give results of my procedure today, and any other prior test results pertaining to my visit today, and any follow up plans with the following person(s):

_____ _____

Signature Date

☐ I request that any information pertaining to my visit today be given only to me.

_____ _____

Signature Date