HUNTSVILLE ENDOSCOPY CENTER

Rajesh Patel, MD **Dino Ferrante, MD** **C. Julian Billings, MD** **John-Paul Voelkel, MD**
Meredith Roath, MD **Mark Moglowsky, MD** **Khurshid Yousuf, MD**

119 Longwood Drive SW **Phone: 256-533-6488**
Huntsville, AL 35801 **Fax: 256-533-6495**

PATIENT REGISTRATION

PLEASE COMPLETE (print, write, type, check, and/or select) 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? ☐ Yes ☐ No If Self, Name of Business: ________________________

Employer's Address: ____ How Long Employed? ____________ ☐ Full-Time ☐ Part-Time

Are You a Student? ☐ No ☐ Full-Time ☐ Part-Time

Name of Spouse: _________________________________ Social Security # _________________________ Date of Birth: ____________________

Spouse's Employer : ____ Occupation: _______________________________

In Case of Emergency, Notify: ____ Relationship: ______________________________

Home Phone: ___________________________ Cell Phone: ___________________________ Work 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 You Have Medical Insurance Coverage, 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 hereby authorize any physician or hospital to provide copies of my medical history and treatment to The Huntsville Endoscopy Center. I further agree that a photocopy of this form 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 Huntsville Endoscopy Center 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 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 ______________________________

NETC-032818

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

Indicate Location of Any METAL

❑ **NONE**

Right **Left**

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

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

Patient Label

// HUNTSVILLE ENDOSCOPY CENTER
Rajesh Patel, MD Dino Ferrante, MD C. Julian Billings, MD John-Paul Voelkel, MD
Meredith Roath, MD Mark Moglowsky, MD Khurshid Yousuf, MD
119 Longwood Drive SW
Huntsville, AL 35801
Phone: 256-533-6488
Fax: 256-533-6495

Valuables / Responsible Driver Form

Huntsville Endoscopy Center (HEC) is not responsible for any valuables that are brought into the Center. We request that you, the patient, leave all of your valuables with the patient's responsible adult or driver. Glasses and dentures may remain with the patient if necessary. You are required to remove jewelry, body piercings, hairpins, etc. prior to entering the pre-op area. If an item is not removable, please notify the nurse upon admission to pre-op. There is space available in pre-op/post-op for ambulatory aids such as wheelchairs, walkers, canes, etc.

Huntsville Endoscopy Center requests that your responsible adult and/or driver remain on the premises during your procedure, provide you transportation home, and remain with you as directed by the provider or as indicated on discharge instructions.

If you receive sedation/anesthesia, you will not be able to drive a vehicle, operate machinery, sign documents, or return to work today.

We also request you give HEC staff and your physician permission to discuss your procedure results, discharge care and instructions, and follow-up plans/care with the following person(s). If you choose to remain confidential, any information pertaining to your procedure will be given only to you (with the exception of discharge and care information.

CHECK ONE:

☐ **I DO GIVE PERMISSION TO DISCUSS MY PROCEDURE AND RESULTS.**
Procedure results will be discussed in person or by telephone.

Name of driver and relationship: ______________________________

Additional guest and relationship: ______________________________

Driver cell phone number: ______________________________

Vehicle description: ______________________________

☐ **I DO NOT GIVE PERMISSION TO DISCUSS MY PROCEDURE AND RESULTS.**
Procedure results will remain confidential.

Name of driver and relationship: ______________________________

Driver cell phone number: ______________________________

Vehicle description: ______________________________

I UNDERSTAND THE ABOVE STATEMENTS.

______________________________ ______________________________
Signature **Date**