

# 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    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?     Yes     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 \_\_\_\_\_

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## History & Physical

<b>Patient Name</b>	<b>Age</b>	<b>DOB</b>	<b>Date</b>
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**Check all conditions that apply to patient only.**

<p><b>AIRWAY/COMPLICATIONS WITH SEDATION/ANESTHESIA</b></p> <p><input type="checkbox"/> Difficult Intubation (Breathing Tube Insertion)</p> <p><input type="checkbox"/> TMJ/Limited Mouth Opening      <input type="checkbox"/> Missing/Loose teeth</p> <p><input type="checkbox"/> Extreme Nausea/Vomiting          <input type="checkbox"/> Dentures/Partials</p> <p><input type="checkbox"/> Awareness During Procedure      <input type="checkbox"/> Difficulty Waking Up</p> <p><input type="checkbox"/> Other _____</p> <hr/> <p><b>CARDIAC/CARDIOLOGIST:</b> _____</p> <p><input type="checkbox"/> HTN (High Blood Pressure)</p> <p><input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> High Cholesterol</p> <p><input type="checkbox"/> Heart Disease/Abnormalities *If yes, explain below: * _____</p> <p><input type="checkbox"/> Irregular Heart Rhythm *If yes, explain below: * _____</p> <p><input type="checkbox"/> Heart Attack/MI If yes, date: _____</p> <p><input type="checkbox"/> Pacemaker/Defibrillator</p> <p><input type="checkbox"/> Heart Stent Placement If yes, date: _____</p> <p><input type="checkbox"/> Aneurysm</p> <p><input type="checkbox"/> Other _____</p> <hr/> <p style="text-align: center;"><b>PULMONARY</b></p> <p><input type="checkbox"/> Recent Cold/Respiratory Infection/Fever</p> <p><input type="checkbox"/> Chronic Cough</p> <p><input type="checkbox"/> Home Oxygen (O<sup>2</sup>)</p> <p><input type="checkbox"/> Asthma/Wheezing If yes, use inhaler? _____</p> <p><input type="checkbox"/> SOB/Shortness of Breath</p> <p><input type="checkbox"/> COPD/Emphysema</p> <p><input type="checkbox"/> Sleep Apnea/Snoring If yes, use CPAP? _____</p> <p><input type="checkbox"/> Steroid Use Within Last 6 Months</p> <p><input type="checkbox"/> CHF (Congestive Heart Failure)</p> <p><input type="checkbox"/> Tuberculosis If yes, date: _____</p> <p><input type="checkbox"/> Other _____</p> <hr/> <p style="text-align: center;"><b>GASTROINTESTINAL</b></p> <p><input type="checkbox"/> GERD (Reflux)                              <input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Ulcerative Colitis                           <input type="checkbox"/> Abdominal Pain</p> <p><input type="checkbox"/> Crohn's Disease                             <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> IBS (Spastic Colon)                         <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> History of Colon Polyps                   <input type="checkbox"/> Appetite Loss</p> <p><input type="checkbox"/> Cirrhosis                                       <input type="checkbox"/> Weight Loss</p> <p><input type="checkbox"/> Celiac Disease                               <input type="checkbox"/> Blood in Stool</p> <p><input type="checkbox"/> Barrett's Esophagus                       <input type="checkbox"/> Vomiting Blood</p> <p><input type="checkbox"/> Nausea/Vomiting                           <input type="checkbox"/> Rectal Pain</p> <p><input type="checkbox"/> Liver Disease/Hepatitis      <input type="radio"/> A   <input type="radio"/> B   <input type="radio"/> C</p> <p><input type="checkbox"/> Dysphagia/Difficulty Swallowing</p> <p><input type="checkbox"/> Other _____</p>	<p style="text-align: center;"><b>NEURO</b></p> <p><input type="checkbox"/> Seizures *If yes, explain below: * _____</p> <p><input type="checkbox"/> Paralysis</p> <p><input type="checkbox"/> Neuropathy</p> <p><input type="checkbox"/> Stroke/TIA</p> <p><input type="checkbox"/> Migraines</p> <p><input type="checkbox"/> Parkinson's/Tremors</p> <p><input type="checkbox"/> Dementia/Alzheimer's</p> <p><input type="checkbox"/> Mental Disability/Intellectual Disability</p> <p><input type="checkbox"/> Other _____</p> <hr/> <p style="text-align: center;"><b>RENAL</b></p> <p><input type="checkbox"/> Kidney Disease                              <input type="checkbox"/> Edema/Fluid Retention</p> <p><input type="checkbox"/> Dialysis                                       <input type="checkbox"/> Prostate Enlargement</p> <p><input type="checkbox"/> Other _____</p> <hr/> <p style="text-align: center;"><b>ENDOCRINE</b></p> <p><input type="checkbox"/> Diabetes      <input type="radio"/> IDDM/Insulin      <input type="radio"/> NIDDM/Non-Insulin</p> <p><input type="checkbox"/> Thyroid Disease</p> <p><input type="checkbox"/> Pancreatic Disease</p> <p><input type="checkbox"/> Other _____</p> <hr/> <p style="text-align: center;"><b>MUSCULOSKELETAL</b></p> <p><input type="checkbox"/> Arthritis      <input type="radio"/> Osteoarthritis      <input type="radio"/> Rheumatoid Arthritis</p> <p><input type="checkbox"/> Multiple Sclerosis                           <input type="checkbox"/> Fibromyalgia</p> <p><input type="checkbox"/> Chronic Back/Neck Pain                   <input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Other _____</p> <hr/> <p style="text-align: center;"><b>OTHER</b></p> <p><input type="checkbox"/> CANCER of      <input type="radio"/> Colon      <input type="radio"/> Other</p> <p><input type="checkbox"/> Bleeding Disorder *If yes, explain below: * _____</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> HIV/AIDS</p> <p><input type="checkbox"/> Other Infectious Disease _____</p> <p><input type="checkbox"/> SKIN:   <input type="checkbox"/> Open Wounds   <input type="checkbox"/> Lesions   <input type="checkbox"/> Burns   <input type="checkbox"/> Bruising</p> <p>If yes, location: _____</p> <p><input type="checkbox"/> Other _____</p> <hr/> <p style="text-align: center;"><b>PSYCHIATRIC</b></p> <p><input type="checkbox"/> Anxiety/Depression                           <input type="checkbox"/> ADD/ADHD</p> <p><input type="checkbox"/> Mental Disorder *If yes, explain below: * _____</p> <hr/> <p style="text-align: center;"><b>SOCIAL HISTORY</b></p> <p><input type="checkbox"/> Cigarettes _____ packs per _____ day _____ years</p> <p><input type="checkbox"/> Other Tobacco Use _____</p> <p><input type="checkbox"/> Alcohol If yes, how much/often? _____</p> <p><input type="checkbox"/> Drugs      <input type="checkbox"/> Marijuana      <input type="checkbox"/> Cocaine      <input type="checkbox"/> Meth</p> <p><input type="checkbox"/> Other _____</p>
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Patient Name

PROCEDURE:  Colonoscopy  Esophagogastroduodenoscopy  Flexible Sigmoidoscopy  Other

Reason for Today's Procedure/Symptom: \_\_\_\_\_

**ALLERGIES/REACTIONS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Indicate Location of Any METAL

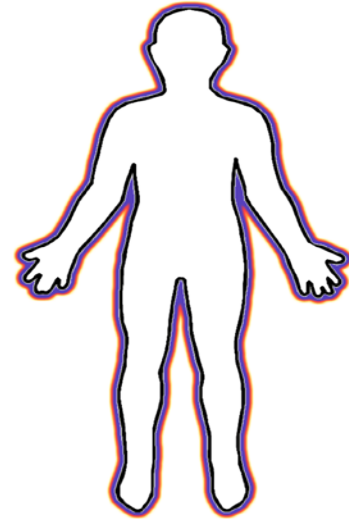
NONE

Right

Left

**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

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.

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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):

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Signature \_\_\_\_\_ Date \_\_\_\_\_

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

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Signature \_\_\_\_\_ Date \_\_\_\_\_