THE CENTER FOR COLON AND DIGESTIVE DISEASE

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

119 Longwood Dr. SW
Huntsville, AL 35801

2007 Gallatin St. SW
Huntsville, AL 35801

8263 Madison Blvd., Ste. E
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: ○ American Indian/Alaskan Native ○ Asian ○ Black ○ African American
○ Native Hawaiian ○ Other Pacific Islander ○ White
○ Multicultural ○ Refuse to report ○ Unknown

Ethnicity: ○ Hispanic/Latino ○ Non-Hispanic/Non-Latino ○ Decline ○ 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

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? _____

CENTER FOR COLON
& DIGESTIVE DISEASE

Cancellation Policy, Authorization and Assignment, and Consent to Contact Form

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 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 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 administration fee if you have to be invoiced for your co-pay.

AUTHORIZATION & ASSIGNMENT: Please Read & 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 THE CONSUMER BY CELLULAR 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/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 e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial messages and/or use of an 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 costs of collection, including a reasonable attorneys 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/Huntsville Endoscopy Center. 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 _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

1. This is to inform you that The Center for Colon and Digestive Disease, P.C. may use and disclose your health information that identifies you and that consists of your past, present, or future physical or mental health or condition, the provision of your healthcare; and the past, present, or future payment of your healthcare (this health information is referred to herein as "protected health information").

2. The use and disclosure of your protected health information will be to carry out treatment, payment, and healthcare operations for The Center for Colon and Digestive Disease, P.C.

3. You have the right to request that The Center for Colon and Digestive Disease, P.C. be restricted from using or disclosing your protected health information in carrying out treatment, payment, or health care operations; however, The Center for Colon and Digestive Disease, P.C. is not required to agree to your requested restrictions. If The Center for Colon and Digestive Disease, P.C. does agree to your requested restrictions, then it will comply with your request.

4. You have the right to revoke this consent. This revocation must be made in writing to The Center for Colon and Digestive Disease, P.C. This revocation will be valid except to the extent that The Center for Colon and Digestive Disease, P.C. has taken action in reliance on this consent.

☐ I, the undersigned, consent to receive telephone calls from The Center for Colon and Digestive Disease, P.C. at any of the telephone number(s) I have supplied including wireless/cellular number(s). I understand that such calls may be generated by an automated dialing system and that I may be charged a fee for such calls by my wireless carrier.

☐ Further, I hereby authorize and give my consent to The Center for Colon and Digestive Disease, P.C. to communicate any of my protected health information to the following persons:

NAME	RELATIONSHIP

REFERRING PHYSICIAN	ADDRESS

☐ I acknowledge receipt of The Notice of Privacy Practices form which details how protected health information may be used and disclosed and how I may access that information.

_____ _____ _____
Patient Name (PLEASE PRINT) Date Patient Signature

Patient Date of Birth _____ Patient Social Security Number _____

_____
Signature (AUTHORIZED REPRESENTATIVE)

The Center for Colon and Digestive Disease, P.C.

Your physician or his/her nurse practitioner, who is a member of The Center for Colon and Digestive Disease, P.C. (CCDD), may order a Computerized Tomography (CT) scan which he/she believes may be needed to better evaluate and assist your case. As a result, federal regulations require that we provide you with the following notice.

CT Scan Notification

Because CCDD owns and provides CT scan services, this notice is being provided to notify you regarding other available facilities that provide CT scan services, in addition to CCDD's. You have the option of having the CT scan provided by CCDD or can choose another facility to have your CT scan. Below are five facilities that provide CT scans, which are within a 25-mile radius of CCDD. This list is not an endorsement or recommendation by CCDD of any of the following activities.

Huntsville Hospital Imaging Center
1963 Memorial Parkway
Huntsville, AL 35801
(256) 265-2311

The Center for Imaging Excellence
2003 Whitesburg Dr. SE
Huntsville, AL 35801
(256) 536-3550

Outpatient Diagnostic Center
115 Saint Clair Avenue
Huntsville, AL 35801
(256) 534-5600

Crestwood Medical Center
700 Airport Rd., Suite H
Huntsville, AL 35801
(256) 429-4888

The Imaging Center
1811 Beltline Rd. SW
Decatur, AL 35601
(256) 341-9307

You have the right to choose the provider of your healthcare services. Although we believe the CT machine located at our office will be able to meet your needs, you have the option to use another healthcare facility. You will not be treated differently by your physician or his/her nurse practitioner if you choose to use a different facility.

Please check the appropriate box below:
□ Yes, I would like to have my imaging studies done at this facility.
□ No, I do not wish for my studies to be done here. I will choose another facility when requested.

_____ _____

Signature of Patient and/or Legal Guardisn | Date

_____ _____

Printed Patient Name | Date

Patient Name: _____ **DOB:** _____ **Date of Visit:** _____

If a physician (or other healthcare provider) referred you for today's visit, then please indicate the name here: _____

Reason for today's visit: _____

_____

YOUR CURRENT SYMPTOMS

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

General
- ☐ Fever
- ☐ Fatigue
- ☐ Swelling of extremities

Skin
- ☐ Itching Skin
- ☐ Rash

Head, Ears, Eyes, Nose & Throat
- ☐ Hoarseness
- ☐ Sore throat

Respiratory
- ☐ Cough
- ☐ Shortness of breath

Cardiovascular
- ☐ Chest pain
- ☐ Irregular heartbeat

Digestive Tract Symptoms
- ☐ Heartburn
- ☐ Difficult or painful swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood or coffee grounds
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Jaundice (yellow skin or eyes)
- ☐ Bloody or tar-like stool
- ☐ Bloating or swelling
- ☐ Anal or rectal pain

Urinary Tract
- ☐ Urinating frequently
- ☐ Urgent need to urinate

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling

Neurological
- ☐ Confusion
- ☐ Numbness or tingling

Psychiatric
- ☐ Anxiety
- ☐ Depression

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance

Hematology
- ☐ Easy bruising
- ☐ Enlarged lymph nodes

☐ None of the above

IMMUNIZATION:
FLU SHOT: YES ◯ NO ◯
PNEUMONIA SHOT: YES ◯ NO ◯

ADVANCE DIRECTIVE: YES ◯ NO ◯

IMPORTANT
*Pharmacy _____

Patient Name: _____ DOB: _____ Date: _____

Pharmacy Information: _____

MEDICATION LIST

PLEASE LIST ALL OF THE 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.

Medication Name	Strength	Dosage

☐ I have **NO** known drug allergies.

I HAVE THE FOLLOWING DRUG ALLERGIES:

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
- ☐ Anticoagulation (blood thinner therapy)
- ☐ Anxiety/depression
- ☐ Asthma
- ☐ Barrett's esophagus
- ☐ Bleeding disorder
- ☐ Blood clots (location in body _____)
- ☐ Breast cancer
- ☐ Celiac disease or sprue
- ☐ Chronic renal failure syndrome
- ☐ Colon cancer
- ☐ Colon polyps
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Coronary artery stent placement
- ☐ Crohn's disease
- ☐ Diabetes mellitus
- ☐ Dialysis (peritoneal or hemodialysis)
- ☐ Diverticulosis
- ☐ Diverticulutis (infected diverticulosis)
- ☐ Emphysema
- ☐ Esophageal cancer
- ☐ Esophageal reflux disease (GERD)
- ☐ Esophageal varices
- ☐ Fatty liver
- ☐ Gallbladder stones or disease
- ☐ Gastritis
- ☐ Glaucoma
- ☐ Gout
- ☐ Hemorrhoids
- ☐ Hepatitis (type, if known _____)
- ☐ Hiatal hernia
- ☐ History of Helicobacter pylori infection
- ☐ High blood pressure or hypertension
- ☐ High cholesterol
- ☐ HIV (human immunodeficiency virus)
- ☐ Home oxygen
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Insulin therapy
- ☐ Iron deficiency anemia
- ☐ Irritable bowel syndrome
- ☐ Lactose intolerance
- ☐ Liver cancer
- ☐ Lung cancer
- ☐ Lymphoma
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Pancreatic cancer
- ☐ Personal history of bowel obstruction
- ☐ Prostate cancer
- ☐ Radiation therapy for prostate cancer
- ☐ Rheumatoid arthritis
- ☐ Schizophrenia
- ☐ Seizure disorder
- ☐ Sleep apnea (do you require C-PAP _____)
- ☐ Stomach or duodenal ulcer
- ☐ Stroke (cerebrovascular accident)
- ☐ TIA (transient ischemic attack)
- ☐ TB (tuberculosis)
- ☐ Ulcerative colitis
- ☐ Valvular heart disease

- ☐ None of the above

SOCIAL HISTORY

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

Tobacco:

- ☐ Cigarettes: _____ Day
- ☐ Never smoked

Alcohol: Yes ◯ No ◯

Use of Recreational Drugs or Substances
(Name of substance 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 _____
- ☐ Hepatitis _____
- ☐ Bleeding disorder _____
- ☐ Pancreatic disease _____
- ☐ Colon polyps _____
- ☐ Ulcerative Colitis _____
- ☐ Colon cancer _____
- ☐ Other _____

- ☐ None of the above

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

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

Transplant

- ☐ Liver transplant
- ☐ Kidney transplant

Genitourinary

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

Other

- ☐ Mastectomy (side _____)
- ☐ 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 Polyps: Yes ○ No ○ Colon Cancer: Yes ○ No ○ Year: _____
- ☐ Gastroscopy Ulcers: Yes ○ No ○ Year _____
- ☐ ERCP Year _____

☐ None of the above