# THE CENTER FOR COLON AND DIGESTIVE DISEASE

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

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, type, circle, or select)**

Full Name:_______________________________________________ Date of Birth:___________________

Social Security#:_____________________________________________________________________

Sex:_________________    Marital Status:

Language: (Please give preferred Language)____________________________________________

**The *enclosed* categories are required for compliance with U.S. Government regulations.**

Race:

Ethnicity:

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?

Self-Employed?    If Self Employed, Name of Business:_____________________________

Occupation:____________________________ How Long Employed?______________

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?

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?    If Yes, Whom?___________________

Do you have Medical Coverage? Primary Insurance Company:______________________

I.D. #:________________________________________ Group #:_____________________________________

Subscriber's Name:___________________________________ Relationship to Patient:___________________

Secondary Insurance Company:____________________ I.D. #________________ Group #:______________

Subscriber's Name:___________________________________ Relationship to Patient:___________________

**<u>If Responsible Party is Other than the Patient, Please Complete The following:</u>**

Responsible Party Name:___________________________________ Relationship:_____________________

Address:_____________________________________ City:______________ State:_____ Zip:___________

Date of Birth:____________________ Social Security #:__________________________________________

Employer:______________________________________________________________

Home Phone:___________________ Cell phone:___________________ Work Phone:_________________

Email Address:____________________________________________________________________________

**In order to provide our patients with the highest level of care, any <u>procedure cancellation</u> 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. <u>This fee must be paid prior to the completion of your P.A. form</u>. There is also a $15.00 administration fee if you have to be invoiced for your Co-pay.**

**<u>AUTHORIZATION & ASSIGNMENT:</u> 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.**

**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 <u>cost of collection</u>, 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.**

**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 of Visit:**

## YOUR PERSONAL MEDICAL HISTORY

Please check the appropriate box(es) for your past or ongoing medical conditions.

- Allergic rhinitis
- Anal warts
- 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
- COPD (chronic obstructive pulmonary disease)
- Coronary artery disease
- Coronary artery stent placement
- Crohn's disease
- Diabetes mellitus
- Dialysis (peritoneal or hemodialysis)
- Diverticulosis
- Diverticulitis (infected diverticulosis)
- Elevated triglycerides
- Emphysema
- Esophageal cancer
- Esophageal reflux disease (GERD)
- Esophageal stricture
- Esophageal varices
- Fatty liver
- Fibromyalgia
- Gallbladder stones or disease
- Gastritis
- Genital herpes
- Glaucoma
- Gout
- Grave's disease
- 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
- Inguinal hernia
- Insulin therapy
- Iron deficiency anemia
- Irritable bowel syndrome
- Ischemic colitis
- Kidney stones
- Lactose intolerance
- Liver cancer
- Lung cancer
- Lymphoma
- Migraine headaches
- Osteoarthritis
- Osteoporosis
- Osteopenia
- Pancreatitis
- Pancreatic cancer
- Pernicious anemia
- Personal history of bowel obstruction
- Prostate cancer
- Prostate enlargement
- Radiation therapy for prostate cancer
- Rheumatoid arthritis
- Schizophrenia
- Seizure disorder
- Sinusitis
- Sleep apnea (do you require C-PAP )
- Stomach or duodenal ulcer
- Stroke (cerebrovascular accident)
- TB (tuberculosis)
- TIA (transient ischemic attack)
- Transfusion of blood or blood products
- 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
- Cigars: Day
- Snuff: Day
- Chew: Day
- Recently quit
- Never smoked

Alcohol:

Type:

- Amount:
- Years:
- Never consumed:

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
- Crohn's disease
- 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
- ☐ 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

**Patient Name:**______________________________________**DOB:**_________________**Date:**__________________

**Pharmacy Information:**____________________________________________________________________________

**Medication List**

**PLEASE LIST ALL 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 |
|---|---|---|
| | | |
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| | | |
| | | |

**I have NO known drug allergies.**

**I HAVE THE FOLLOWING DRUG ALLERGIES:**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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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.

- ☐ 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)

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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:** ____________________________________________

**Release these records:** **Initials**

1. **Only records generated by this facility (not including records received from other sources)** _______
2. **Only some portion of records maintained at facility (dates of treatment, etc., specify below)** _______
3. **All medical records at this facility** ____________________________________________

____________________________________________

**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**
_______ **Psychological or psychiatric conditions, if any**

**Initials**
______ **AID/HIV, 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):**

______________________________

______________________________

**Patient Signature**

**Date:** _____/______/______

**Person authorized to sign for patient:**

______________________________

______________________________

**Signature**

**Date:** ______/_______/_______