THE CENTER FOR COLON AND DIGESTIVE DISEASE

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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: ____________________

Can We Call Them at Work if Necessary? ☐ Yes ☐ No Work Phone: ____________ Cell Phone: ____________

If Responsible Party is Other Than Patient, Please Complete:

Responsible Party Name: ____________________ Relationship: ____________

Address:____________________ City: ____________ State: ________ Zip: ____________

DOB: ________ Social Security # ____________ Employer: ____________________ ☐ Full Time ☐ Part Time

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

In Case of Emergency, Notify: ____________________ Relationship: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Who Referred You to This Office? ____________________

Who Is Your Regular Family Physician? ____________________

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 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 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** ____________________

Patient Name: ____ **DOB:** __________________ **Date:**__________________

Referring Physician: _______________________________ **Reason for Visit:** ____________________________________

Location: _____________ **Severity (Scale 1-10)** _____ **Duration (How long)** _________ **Timing (When it occurs)** _______

CURRENT SYMPTOMS

Please check any of the following that 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 with or without exertion
- ☐ Irregular heartbeat
- ☐ Leg pain when walking
- ☐ Swelling of extremities

Gastroenterology
- ☐ Abdominal pain
- ☐ Belching
- ☐ Bloating
- ☐ Bloody stool
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Rectal pain
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Vomiting coffee ground appearance
- ☐ Appetite loss
- ☐ Weight loss _______ lbs.

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
- ☐ Weakness
- ☐ Confusion

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

Family History
*Please list family member

- ☐ Heart disease ________________________
- ☐ Hepatitis ____________________________
- ☐ Bleeding disorder _____________________
- ☐ Peptic ulcer disease ____________________
- ☐ Pancreatic disease _____________________
- ☐ Irritable bowel syndrome ______________
- ☐ Colon polyps ________________
- ☐ Colitis ______________________
- ☐ Colon cancer _________________
- ☐ Crohn's disease _______________
- ☐ **NONE OF THE ABOVE**

Personal History

- ☐ Anemia
- ☐ Barrett's esophagus
- ☐ Celiac disease or sprue
- ☐ Colitis
- ☐ Colon cancer
- ☐ Colon polyps
- ☐ Constipation
- ☐ Crohn's disease
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Fatty liver
- ☐ Gallbladder problems
- ☐ Gastric ulcer
- ☐ Gastritis
- ☐ Gastroesophageal reflux disease
- ☐ Helicobacter pylori
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ Irritable bowel syndrome
- ☐ Ischemic colitis
- ☐ Pancreatitis
- ☐ Peptic ulcer
- ☐ Ulcerative colitis
- ☐ Allergic rhinitis
- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Breast cancer
- ☐ Cancer
- ☐ Chronic renal failure syndrome
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Diabetes mellitus
- ☐ Dialysis
- ☐ Emphysema of lung
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Grave's disease
- ☐ Heart failure
- ☐ Hereditary disease
- ☐ High blood pressure
- ☐ Hospitalizations
- ☐ Date: _________________________
- ☐ Reasons: ______________________
- ☐ Hypercholesterolemia
- ☐ Hyperlipidemia
- ☐ Inguinal hernia
- ☐ Lactose intolerance
- ☐ Liver cancer
- ☐ Lung cancer
- ☐ Lymphoma
- ☐ Migraine headaches
- ☐ Prostate cancer
- ☐ Schizophrenia
- ☐ Seizure Disorder
- ☐ Sexually transmitted disease
- ☐ Sinusitis
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Transplantation: Liver
- ☐ Transplantation: Lung
- ☐ Transplantation: Renal
- ☐ Valvular heart disease
- ☐ **NONE OF THE ABOVE**

Social History:

Tobacco:

- ☐ Cigarettes: ______ day
- ☐ Cigars: _________ day
- ☐ Snuff: __________ day
- ☐ Chew: __________ day
- ☐ Recently quit ________

Alcohol:
Type: ___________________________________
- ☐ Amount _______________________
- ☐ Years: ________________________

Illicit Drug Use: ______Yes ______ No
Type: ____________________________________

Patient Name___________________________ **DOB**_________________ **Date**___________________

Surgeries

*Please check any of these surgeries you have had in the past.

Gastrointestinal

- ❑ Appendectomy
- ❑ Cholecystectomy (Gallbladder)
- ❑ Colectomy
- ❑ Colon resection
- ❑ Exploratory surgery for adhesions
- ❑ Fundoplication
- ❑ Gastric bypass
- ❑ Gastric resection
- ❑ Hemorrhoidectomy
- ❑ Inguinal hernia repair
- ❑ Splenectomy
- ❑ Ventral hernia repair
- ❑ Whipple

Cardiac

- ❑ Abdominal aortic aneurysm repair
- ❑ Coronary artery bypass graft
- ❑ Femoral bypass
- ❑ Heart stent placed
- ❑ Heart valve surgery

Genitourinary

- ❑ TURP
- ❑ Inguinal hernia repair
- ❑ Cystectomy with ileal conduit
- ❑ Nephrectomy
- ❑ Prostatectomy
- ❑ Radiation for prostate cancer

Gynecological

- ❑ Hysterectomy
- ❑ Hysterectomy, abdominal
- ❑ Hysterectomy, vaginal
- ❑ Oopherectomy
- ❑ Cesarean delivery
- ❑ Breast biopsy

Other

- ❑ Breast augmentation
- ❑ Breast reduction, both
- ❑ Cataract surgery
- ❑ Glaucoma surgery
- ❑ Laser surgery
- ❑ Mastectomy
- ❑ Prostate surgery
- ❑ Skin lesion, local excision
- ❑ Thyroidectomy
- ❑ Urinary surgery

Previous Endoscopic Procedures

- ❑ Colon _______findings _____ year
- ❑ EGD _______ findings _____ year
- ❑ Other _______ findings _____ year

- ❑ **NONE OF THE ABOVE**

Medication List

Name: ____ **Date:** ____________

Pharmacy Information: ____

☐ **Currently on NO Medications**

Medication Name	**Strength**	**Dosage**

☐ **NO Known Drug Allergies**

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 ______ Signature (PATIENT) ______

______(Date of Birth) ______ (Social Security Number)

______
Signature (AUTHORIZED REPRESENTATIVE)