

HUNTSVILLE ENDOSCOPY CENTER

Walter Meyer, MD Michael W. Brown, MD C. Allen Goetsch, MD Rajesh Patel, MD Dino Ferrante, MD
Joseph Brasco, MD C. Julian Billings, MD Robert A. Pendley, MD Bradley Rice, MD John-Paul Voelkel, MD
119 Longwood Drive, Huntsville, AL 35801 Phone: (256) 533-6488 FAX: (256) 533-6495

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: _____

In Case of Emergency, Notify: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell 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 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:

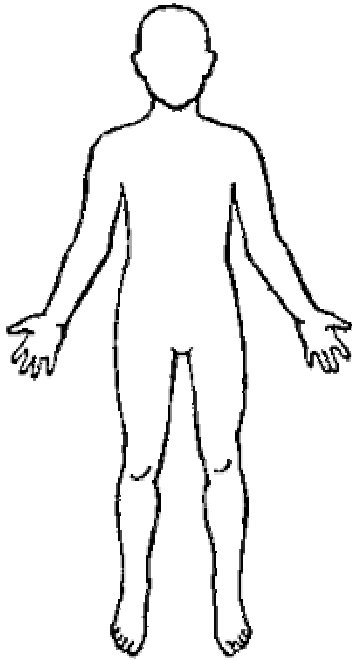
I directly assign all medical/surgical benefits to Huntsville Endoscopy Center and understand that I am financially responsible for all charges not covered by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy 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 _____

Indicate Location of Any Metal

none



Mode of arrival: ambulatory cane walker wheelchair stretcher

Physical/Mental disability none _____

Language barrier none _____

ETOH Use: none _____

Recreational Drug Use none _____

C/O Pain none **Location/Severity (1-10)** _____

C/O Nausea none **Severity (1-10)** _____

NPO status: _____

BOWEL PREP (if applicable): _____

Patient description of last bowel movement: _____

IV Access: Site: _____ Gauge _____ Time: _____ Nurse: _____

Problems/Complications, if any _____

IVF: 500mL Normal Saline @ KVO rate Other _____

Blood Glucose N/A _____ mg/dL Time: _____

Urine HCG N/A negative positive Time: _____

Additional Comments: _____

PRE-PROCEDURE ECG TRACING

TIME _____

POST-PROCEDURE ECG TRACING

TIME _____

History and Physical Reviewed By:

Assessment Nurse: _____

Sedating Nurse: _____

Physician: _____

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.

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):

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

Signature/Date