THE CENTER FOR COLON AND DIGESTIVE DISEASE

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2007 Gallatin Street SW
Huntsville, AL 35801

8263 Madison Blvd., Suite 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/Alaska 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

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? ☐ Yes ☐ No If Yes, Whom? _____

Do you have Medical 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 Responsible Party is Other than the Patient, Please Complete The following:

Responsible Party Name: _____ Relationship: _____

Address:_____ City:_____ State:_____Zip: _____

Date of Birth:_____ Social Security #:_____

Employer: _____ ☐ Full-time ☐ Part-time

Home Phone: _____ Cell phone:_____ Work Phone:_____

Email Address: _____

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 $75.00 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. This fee must be paid prior to the completion of your P.A. form. There is also a $15.00 administration fee if you have to be invoiced for your co-pay.

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 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 CONSUMER BY CELL 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, PC. 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 insurance or myself, I agree to pay all cost 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 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. 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_____

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)** 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

☐ **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.

☐ 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)

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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: _____

Records to release (enter your initials):

Initials	**Records:**
_____	All medical records at this facility
_____	Only records generated by this facility (not including records received from other sources)
_____	Only some portion of records maintained at facility (dates of treatment, etc., please specify)

_____

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
_____	AIDS/HIV, if any
_____	Psychological or psychiatric conditions, 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 (print):

_____

_____

Signature

Date: _____/_____/_____