

Columbia Gastrointestinal Endoscopy Center

Please check: Bristow Galan Kimbrough Mann Postic Villanueva Account # _____

PATIENT INFORMATION

PATIENT: _____ SOCIAL SECURITY #: _____

ADDRESS: _____ DATE OF BIRTH: _____ AGE: _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

I authorize Columba GI Endoscopy Center to leave messages pertaining to my healthcare or finances at the following numbers:

CELL _____ HOME _____ (Please inform receptionist if you decline voicemail messages)

E-mail Address _____ Sex at Birth: Female Male

FAMILY/REFERRING PHYSICIAN _____ Marital Status: M S D W

RACE: African America Caucasian American Indian Asian Other _____

ETHNICITY Hispanic or Latino Non-Hispanic or Latino HAVE YOU HAD A PREVIOUS PROCEDURE AT OUR CENTER? Yes No

DO YOU HAVE AN ADVANCED DIRECTIVE or LIVING WILL? Yes No IF NOT, WOULD YOU LIKE INFORMATION? Yes No

PRIMARY INSURANCE INFORMATION

COMPANY _____ PHONE _____

ADDRESS _____ CITY, STATE, ZIP _____

MEMBER # _____ GROUP# _____

NAME OF INSURED _____ INSURED SOCIAL SECURITY _____

INSURED DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE INFORMATION

COMPANY _____ PHONE _____

ADDRESS: _____ CITY, STATE, ZIP _____

MEMBER # _____ GROUP# _____

NAME OF INSURED: _____ INSURED SOCIAL SECURITY: _____

INSURED DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

EMPLOYMENT INFORMATION

EMPLOYER _____ PHONE _____

Procedure and Billing Communication Authorization/ Emergency Contact

I authorize Columbia GI Endoscopy Center and/or the physician performing my procedure today to communicate information regarding my procedure/results of my procedure/billing to/with:

CONTACT _____ Phone # _____ RELATIONSHIP _____

Emergency contact if different from above: _____ Phone # _____ RELATIONSHIP _____

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

Signed (Patient or Responsible Party) _____ Date _____

Columbia Gastrointestinal Endoscopy Center

MEDICAL HISTORY. Please COMPLETE ENTIRE FORM. (We do not have access to your physician's records)

I have not had anything by mouth (including medication) since _____ a.m. p.m. Today Yesterday
COLONOSCOPY PATIENTS - Were you on a clear liquid diet **ALL DAY** yesterday and today? Yes No

Which procedure are you having done? (Check all that apply)

- Colonoscopy EGD-Upper endoscopy
 Esophageal Dilation Sigmoidoscopy

Colonoscopy patients, which prep did you use?

- Gavalte, (Gallon jug) Clenpiq Suflav Suprep
 Sutab Plenvu, other _____.

What time did you finish drinking prep? _____ Describe results:
 Clear Yellow Brown Blood seen? Yes No

I HAVE NO MEDICAL/HEALTH CONDITIONS or
Please check all that apply:

I have brought <input type="checkbox"/> Glasses <input type="checkbox"/> Dentures <input type="checkbox"/> Hearing aid <input type="checkbox"/> Contacts
<input type="checkbox"/> Parkinsons disease <input type="checkbox"/> I use a Walker, Cane, Wheelchair
<input type="checkbox"/> I have fallen in the past year
<input type="checkbox"/> Diabetes Do you take insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did you check your blood sugar today? <input type="checkbox"/> Yes <input type="checkbox"/> No Result _____ Time _____
<input type="checkbox"/> BLOOD THINNER USE Last dose taken date _____ Plavix, Eliquis, Xarelto, Pradaxa, Coumadin,
<input type="checkbox"/> HEART DISEASE <input type="checkbox"/> CAD <input type="checkbox"/> Previous Heart attack <input type="checkbox"/> High blood pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Heart Stents <input type="checkbox"/> Atrial fibrillation <input type="checkbox"/> Pacemaker <input type="checkbox"/> Artificial heart valve <input type="checkbox"/> Stroke <input type="checkbox"/> CHF <input type="checkbox"/> other heart problems
<input type="checkbox"/> CARDIAC DEFIBRILLATOR (Please call the office, we cannot do your procedure here)
<input type="checkbox"/> SLEEP APNEA Do you use a CPAP? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> COPD <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> other breathing issues _____
<input type="checkbox"/> HIV <input type="checkbox"/> Hepatitis A/B/C <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Other liver disease
<input type="checkbox"/> Glaucoma <input type="checkbox"/> Arthritis <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hyperthyroid
<input type="checkbox"/> Kidney disease <input type="checkbox"/> Dialysis <input type="checkbox"/> Shunt in arm
<input type="checkbox"/> Cancer Type _____
<input type="checkbox"/> No BP or IV sticks in one of my arms <input type="checkbox"/> right <input type="checkbox"/> left
<input type="checkbox"/> Artificial pins or plates (ex. knee, hip, shoulder) Location _____ Year performed _____
<input type="checkbox"/> Internal Stimulators (nerve, spinal, bladder) Location _____ Is the stimulator off? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Seizure Disorder Date of last seizure _____
<input type="checkbox"/> Other medical conditions not listed _____
<input type="checkbox"/> Never Smoker <input type="checkbox"/> Former smoker <input type="checkbox"/> Current Smoker/vape Did you smoke today <input type="checkbox"/> No <input type="checkbox"/> Yes Amt smoke _____ per day
<input type="checkbox"/> Social/Occasional alcohol <input type="checkbox"/> Daily alcohol <input type="checkbox"/> Never <input type="checkbox"/> Illicit Drug use (marijuana, etc.) <input type="checkbox"/> I have a history of substance abuse (alcohol, opiates, etc.) that may increase my anesthesia requirement.

Why are you having the procedure?

- First colonoscopy Age related colon screening
 History of colon polyps History of Colon Cancer
 Family history of colon cancer _____
 Abdominal pain Ulcerative colitis Crohn's Disease
 Diarrhea Constipation Rectal bleeding Blood in stool
 Last colonoscopy performed when? _____
 Reflux Heartburn Barretts Nausea Vomiting
 Difficulty swallowing, Anemia, Other _____

Females/ Have you had a hysterectomy or tubal ligation Yes No
 Would you like a pregnancy test? Yes No

I have no allergies, sensitivity or reactions to medications, foods, material, environmental factors

LIST all allergies, sensitivities and reactions: (include over the counter meds & food allergies)

Med, food, etc.: _____ Reaction: _____
 Med, food, etc.: _____ Reaction: _____
 Med, food, etc.: _____ Reaction: _____
 Med, food, etc.: _____ Reaction: _____

I have had no surgical procedures OR

LIST all surgical procedures:

I take no medications or supplements OR

LIST all medications: IMPORTANT!! (List ALL meds, doses (mg), how often (daily, twice a day) and last taken)

Med _____ Last taken _____
 Med _____ Last taken _____
 Med _____ Last taken _____
 Med _____ Last taken _____
 Med _____ Last taken _____
 Med _____ Last taken _____
 Med _____ Last taken _____
 Med _____ Last taken _____
 Med _____ Last taken _____
 Med _____ Last taken _____
 Med _____ Last taken _____

(STAFF USE ONLY)
 Ht _____ WT _____ BP _____ T _____ HR _____ RR _____ O2 _____

Driver's Name _____ Do you have an Advance Directive / Living will? No Yes
 Driver's Phone # _____ In Waiting room In Car Bring Driver to Recovery Don't bring back
I understand my driver must remain on the premises. I understand the Center is not responsible for any valuables I have brought with me.
 Patients Signature _____ Date _____