# PATIENT REGISTRATION (please print)

1. Chart Number ______________________________
2. Patient's Full Name ______________________________ (Last, First, Middle, Name Preferred) 3. Sex: ☐ M ☐ F
4. Race: (Please Circle) American Indian, Asian, African American, Native Hawaiian or Pacific Islander, Caucasian, Other, Patient Declined
   Ethnicity: (Please Circle) Non-Hispanic, Hispanic, Patient Declined    Preferred Language ______________
5. Patient's Social Security # ______________    6. Date of Birth: ______________    Age: ______
7. Patient's Home Address ______________________________ (Street or Route, City, State, Zip)
   Patient's Email Address ______________________________
8. Primary Care Doctor ______________    9. Financial Responsibility: ☐ Patient ☐ Other
10. Referring Doctor ______________________________
11. Patient's Phone(s) #: Home # ( _____ ) ______________ Work # ( _____ ) ______________ Cell # ( _____ ) ______________
    Preferred Notification Method: (please circle) Postal Mail, Phone, Web Message
12. Is the Patient Currently Employed? ☐ Yes ☐ No
    Patient's Employer ______________________________
    Employer's Address ______________________________ (Street or Route, City, State, Zip)
13. Patient's Marital Status ☐ S ☐ M ☐ D ☐ W ☐ Sep.    Spouse Name ______________
14. Person we may contact in case of an emergency: Relationship ______________
    Name ______________    Phone # ______________
    Address ______________________________ (Street or Route, City, State, Zip)

**INSURANCE INFORMATION** – We cannot file your insurance without complete information and a copy of your insurance cards. Please bring your insurance card with you to the front desk when you have completed this form.

**PRIMARY INSURANCE COVERAGE**

15. Insurance Company ______________    Address ______________
16. Subscriber's Name ______________    17. Subscriber's Sex: ☐ M ☐ F
18. Subscriber's Date of Birth ______________    19. Subscriber's Social Security # ______________
20. Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other
21. Subscriber's Employer ______________________________
22. Subscriber's ID # ______________    23. Group # ______________

**SECONDARY INSURANCE COVERAGE**

24. Insurance Company ______________    Address ______________
25. Subscriber's Name ______________    26. Subscriber's Sex: ☐ M ☐ F
27. Subscriber's Date of Birth ______________    28. Subscriber's Social Security # ______________
29. Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other
30. Subscriber's Employer ______________________________
31. Subscriber's ID # ______________    Group # ______________

**OTHER INSURANCE** ☐ Yes ☐ No

FINANCIAL AGREEMENTS AND AUTHORIZATION FOR TREATMENT: I hereby authorize Raleigh Medical Group, Cary Medical Group, Raleigh Adult Medicine and Wake Endoscopy Center ("RMG/CMG/RAM/WEC") and its physicians and such assistants as a physician may designate to furnish and perform on me or the patient stated above ("Patient") such medical care, examination and treatment as may be ordered by an RMG/CMG/RAM/WEC physician in his or her medical judgment and such medical care, examination or treatment as is reasonable incident thereto. I hereby authorize direct payment to RMG/CMG/RAM/WEC of all medical insurance benefits (including without limitation Medicare and Medicaid benefits) to which the Patient is entitled in consideration of services to be rendered by RMG/CMG/RAM/WEC to the Patient. I understand that, to the extent permitted by applicable law, I am and I agree hereby to be, financially responsible to RMG/CMG/RAM/WEC for charges not covered by this agreement, and I hereby guarantee payment to RMG/CMG/RAM/WEC on demand for all such charges.

Signature ______________________________    Please check one: ☐ Patient ☐ Authorized Representative
Date ______________________________    ☐ Parent or Guardian of Minor

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize RMG/CMG/RAM/WEC to furnish, to the extent permitted by applicable law, any medical information acquired in the course of the Patient's examination and/or treatment to any insurance company, government agencies and their agents, and professional review organizations with which the Patient may have insurance coverage or which may be assisting in payment of the medical care provided by RMG/CMG/RAM/WEC to the Patient. I also hereby authorize RMG/CMG/RAM/WEC to release any medical information to any licensed physician, health care provider, or medical facility to which the Patient may be referred, admitted, or transferred for further medical care. I understand that I may revoke this authorization by written notice at any time except to the extent that action has been taken.

Signature ______________________________    Please check one: ☐ Patient ☐ Authorized Representative
Date ______________________________    ☐ Parent or Guardian of Minor

# Endoscopy Pre-Procedure
# Patient History and Physical Form

Chart No: ________________ Date________________

Name__________________________________ Birth date: ___________ Age:_________

GI Physician______________________________ Referred by ______________________

Present Problem______________________________________________________________
Weight__________ Height____________ **BMI:** __________________

**Latex Allergy: Yes____ No____ Reaction___________________________________**
**Allergy to: Eggs_____ Reaction__________ Soy/Soybeans: ____ Reaction __________**
**Language Barrier: Yes_______ No_________ Translator needed: _________________**
**History: (check if applicable)**
**Pregnant: Yes______ No_____ C-Section/How Many:____________________________**
**Endocrine:**
____Diabetes _____ Meds _____ Insulin
**Cardiovascular/Respiratory:**
_____Heart Problems _____Heart Bypass Surgeries _____ High Blood Pressure
_____Stents _____Internal Defibrillator ______Pacemaker
_____Congestive Heart Failure _____Blocked Arteries ______Angina
_____Heart Catheterization
_____Heart Attack _____Irregular Heartbeat ______Valve Replacement
_____ COPD _____Emphysema _____ Home Oxygen
_____Asthma **Date Last Attack_____________ Inhalers____________________________________**
_____**Sleep Apnea If yes, C-PAP Machine_______________**
**Neurological/Renal/GI/Orthopedic:**
____Hx Seizures _____Parkinson's _____Alzheimer's ____Migraines
____Stroke _____Kidney Problems ____Kidney Failure _____Dialysis
____Ulcers _____Crohns ____Colitis _____Bleeding
____Joint Replacement (Joint Replaced_____________) _____Hx Ca
____Hepatitis Type___________________________
____Other____________________________________________________________
**Are you on blood thinners No______ Yes ______**
**Problems Obtaining IV's Yes______ No_______ Fear of Needles: Yes_____ No______**
______________________________________________________________________________
Past complications with sedation No______ Yes ______
List Complications: __________________________________________________________
Do you smoke____ No ____Yes # packs/day_____ Recreational Drug _____No _____Yes
Do you drink alcohol Yes____ No ____ Social ______ Amount __________________________

Surgeries____________________________________________________________________

_____________________________________________________________________________

Disabilities__________________________________________________________________

**GI History: Family/Personal**
Previous EGD: Yes___ No___ Date____ Previous Colonoscopy Yes___ No___ Date______
Personal Hx of Polyps Yes___ No___ Age __________
Family History of Polyps Yes ___ No ___ Relationship ____________ Age ________
Family history of colon cancer Yes ___ No ___ Relationship ____________ Age ________

**Patient:** ____________________________ **Chart:** _______________

**Allergies**: Drug: ___________________ Reaction___________________
Drug: ___________________ Reaction___________________
Drug: ___________________ Reaction___________________
Drug: ___________________ Reaction___________________

**Present Medications: (List over the counter and Herbal Meds also)**

**CURRENT PHARMACY**________________________________________

**(Office Use Only)**

**Drug:** ____________________ **Dose:** __________ **Date/Time Last Taken:** _______________
**Drug:** ____________________ **Dose:** __________ **Date/Time Last Taken:** _______________
**Drug:** ____________________ **Dose:** __________ **Date/Time Last Taken:** _______________
**Drug:** ____________________ **Dose:** __________ **Date/Time Last Taken:** _______________
**Drug:** ____________________ **Dose:** __________ **Date/Time Last Taken:** _______________
**Drug:** ____________________ **Dose:** __________ **Date/Time Last Taken:** _______________
**Drug:** ____________________ **Dose:** __________ **Date/Time Last Taken:** _______________
**Drug:** ____________________ **Dose:** __________ **Date/Time Last Taken:** _______________
**Drug:** ____________________ **Dose:** __________ **Date/Time Last Taken:** _______________

**Hx/Medications Reviewed by Endo Nurse:** ________________________________________

**Date:** ___________________

Revised S Parrish RN 11/16/2011

Wake Endoscopy Center A division of Raleigh Medical Group, P.A.

# SUMMARY OF NOTICE OF PRIVACY PRACTICES

## Effective Date: April 14, 2003

This notice is a description of how medical information about you may be used and disclosed and how you can get access to this information.

For additional information, please refer to the full version of this notice or contact our privacy officer.

Wake Endoscopy Center
2601 Lake Drive,
Suite 201,
Raleigh, NC 27607

Phone: **919-783-4888**

Fax: **919-783-4887**

## USES AND DISCLOSERS OF YOUR PROTECTED HEALTH INFORMATION

We may use or disclose your health information:

- To treat you
- To get paid for treating you
- To run the Practice
- To remind you of appointments
- As may be required or otherwise permitted by law

For more information of how we may use or disclose your health information, please refer to the full version of this notice or contact our Privacy Officer.

We will use or disclose your health information for other purposes only with your authorization. If you authorize us to use or disclose your protected health information for other purposes, you may revoke that authorization at any time by notifying us.

## YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

You have a right to:

- Ask us to limit the information that we have
- Receive confidential communications from us regarding your health information
- Look at and obtain a copy of your health information
- Amend mistakes in your health information
- Obtain a list of disclosures of your health information that we have made; and
- Obtain a copy of the full version of our Notice of Privacy Practices

For more information on how to exercise your rights and how such rights may be limited by law, please refer to the full version of the Notice or contact our Privacy Officer.

## OUR DUTIES WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties with respect to your protected health information and our privacy practices, and to abide by the terms of our Notice of Privacy Practices.

## REVISIONS TO NOTICE OF PRIVACY PRACTICES

We may revise our policies with respect to the privacy of patient health information from time to time. Any amendments to our Notice shall be posted in our offices, and copies of any amended Notice will also be available in our offices.

## COMPLAINTS

If your believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. For more information on how to file a complaint, please refer to the full version of this Notice or contact our Privacy Officer.

## PRIVACY OFFICER CONTACT INFORMATION

If you have any questions regarding your privacy rights, please refer to the full version of this Notice or contact our privacy officer at (919) 859-5955. You may also address questions of concerns to the privacy officer by writing to:

Privacy Officer
530 New Waverly Place
Suite 200
Cary, NC 27518