Norman Endoscopy Center
Patient Registration Information

Date of Procedure: _____ **NEC Physician:** _____
Time of Procedure: _____ **Primary Care Physician:** _____

Patient Name: _____, _____
(last name) (first name) (middle initial) (suffix)

Mailing Address: _____
(street address) (state) (zip code)

Telephone: _____(home) **Emergency Contact:** _____
_____(cell) **Emergency Contact telephone:** _____
_____(work) **Email Address:** _____

Date of Birth: _____
Gender: □ male □ female □ other _____
Do you have any Hispanic origin? □ yes □ no □ unknown
Marital Status: □ single □ married □ widowed □ divorced □ life partner

<u>Insurance Information</u> (please bring insurance cards to appointment)

Primary Insurance:	Secondary Insurance:
Subscriber ID:	Subscriber ID:
Group Number:	Group Number:
Policy Holder's Name:	Policy Holder's Name:
Relationship to the patient:	Relationship to the patient:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:

Co-pays and deductibles will be due on the day of service. As a courtesy, Norman Endoscopy Center will bill your insurance company(s). You will be billed for the amount not paid by your insurance company. If you do not have insurance coverage please call the business office at 405-366-0969 to determine payment options.

Please Note: Norman Endoscopy Center and the physician's offices are separate entities and will bill you separately. The anesthesia provider will send an invoice for their services. If a polyp is removed or tissue is taken during your procedure you will incur two pathology charges: one from company that preps your specimen onto slides and the other from a pathologist who analyzes and reports findings to your physician.

If you have any questions, please do not hesitate to call: 405-366-0969

Please mail or fax this Registration Packet to:

NORMAN ENDOSCOPY CENTER
1515 N. Porter Suite 100
Norman, OK 73071
Fax: 405-701-3734

NORMAN ENDOSCOPY CENTER

Patient label

Authorization

AUTHORIZATION & INFORMATION TO BE SHARED	initial

I authorize Norman Endoscopy Center as set forth below, to share my protected health information for reasons in addition to those already permitted by law. I authorize the release of any medical information necessary to process insurance claims to insurance carriers to be released by Norman Endoscopy Center. As the information authorized for release may include records which may include the presence of a communicable or venereal disease, which may include but not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as aids. I understand my information may be shared with Norman Gastroenterology & Associates.

PAYMENT OF MEDICAL BENEFITS	initial

I hereby request payment of medical benefits to Norman Endoscopy Center, to be paid directly by my insurance company(s).

ADVANCE DIRECTIVE	initial

I hereby acknowledge that Norman Endoscopy Center informed me of their policy regarding Advance Directives. I understand that while a patient at Norman Endoscopy Center, in the event of medical emergency, life saving interventions will be done regardless of the verbage in my Advance Directive. In the event I am transferred to Norman Regional Health Systems my Advance Directive will accompany me. A official State of Oklahoma Advance Directive forms are available at patient request.

RECEIPT OF PRIVACY PRACTICE	initial

I hereby acknowledge receipt of Norman Endoscopy Center's Notice of Privacy Practices.

EHX CONSENT

EHX is the Norman physician hospital exchange. This allows medical records to be shared between Norman Regional Health System and the physicians that practice medicine there.

I authorize the following information to be shared via EHX:	initial

☐❑ Entire medical record *(includes all recordsexcept psychotherapy notes)*	❑ Do not share Medical Records

Information regarding TODAY'S visit may be released to the following person(s):

Name:	phone #
Name:	phone #

Detailed information about my procedure (results) or inquiries about my well being:

- ❑ May be left on the following voicemail _____
- ❑ I do not authorize any message to be left on my voicemail.

RIGHT TO REVOKE: I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of this form. NORMAN ENDOSCOPY CENTER 1515 N. PORTER SUITE 100 NORMAN, OK 73071

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ THE ABOVE REQUIRED INFORMATION. THIS DOCUMENT MUST BE SIGNED BY THE INDIVIDUAL OR THE INDIVIDUAL'S LEGAL REPRESENTATIVE.

SIGNATURE _____ DATE_____

NORMAN ENDOSCOPY CENTER, LLC

ENDOSCOPY PRE-PROCEDURE RECORD

patient label

Height_____ Weight_____ BMI_____ ❑Male ❑Female

Y	N	*DO YOU HAVE, OR HAD, A HISTORY OF THE FOLLOWING:*
		Heart trouble: ❑heart attack, date_____ ❑CHF, ❑stents
		❑chest pain (angina), ❑murmur, ❑pacemaker, ❑defibrillator
		❑valve replacement, ❑irregular heart beat, ❑other_____
		High blood pressure: ❑treated with medications, ❑low BP
		Stroke: date_____, list any lasting effects_____
		Stomach/colon: ❑abdominal pain, ❑dysphagia ❑IBS
		❑ulcer, ❑reflux/GERD/heartburn, ❑esophageal varices
		❑resection, ❑ostomy, ❑diarrhea, ❑bleeding, ❑Crohn's
		❑Barrett's esophagus, ❑nausea/vomiting, ❑other_____
		Lung Disease: ❑asthma, ❑COPD/emphysema, ❑sleep apnea
		❑snoring ❑recent bronchitis ❑abnormal chest xray, date_____
		Tuberculosis: ❑bloody sputum ❑recent wt loss ❑night sweats
		❑persistent cough, ❑+TB test, date_____, treated yes/no
		Recent exposure to HIV, measles, chicken pox, influenza?
		Recent travel outside the US?
		Have you had MRSA, VRE, Creutzfield-Jacob Disease *(aka Mad Cow)*
		Liver disease: ❑cirrhosis, or ❑hepatitis ❑A ❑B ❑C
		Kidney or Bladder Disease: ❑incontinence, ❑other_____
		Diabetes: ❑oral meds, ❑insulin dependent, ❑diet controlled
		Abnormal bleeding: ❑blood thinners, ❑sickle cell trait, ❑other_____
		Cancer: explain type/treatment
		Epilepsy or Seizure disorder? Explain
		Physical limitations? Explain
		Mental, emotional or behavioral problems?
		Learning difficulties or unable to read?
X		**Female history:** could you be pregnant now? ❑yes ❑no
X		last mentrual period_____ Breastfeeding? ❑yes ❑no

LIST ALL PREVIOUS SURGERIES (KIND, DATE):

1
2
3
4
5
6
7
8
9
10

Date of last colonoscopy _____ , EGD_____

Vaccine year, if applicable: influenza_____ pnuemonia_____

Have you ever had abnormal reaction or ill effect from anesthesia or sedation? ❑no ❑yes, _____

List pertinent medical history not addressed:_____

Do you use nicotine? ❑yes ❑past use ❑never

Packs/day?_____ years of use?_____ age quit?_____

Alcohol/recreational drug use? ❑yes ❑no

Use per day, week, month *(circle one)*?_____

I testify that the above information is complete & accurate so that I may be provided a safe procedure outcome.

Patient Signature_____

Informant_____

Collected by_____ Date_____

(area below for office use only)

DAY OF PROCEDURE / PRE-PROCEDURE ASSESSMENT

Procedure Date | Prep Area Arrival Time | NPO @

Name & DOB verified ❑yes ❑no

Procedure verified & permit signed ❑yes ❑n

Clear colon prep results ❑yes ❑no ❑r

Dentures ❑yes ❑no, Jewelry ❑yes ❑r

Glasses ❑yes ❑no, disposition _____

Temp	BP	Pulse	Resp	SpO^2

FSBS_____(65-115) ❑n/a

Current Narcotic / Benzodiazepine use?

❑yes ❑no if yes, list _____

PAIN SCALE

0 *1-2* *3-4* *5-6* *7-8* *9-10*

If pain, describe_____

Nursing System ➔ Assessment **X = as stated, O = see notes for explanation**

	Neurological	alert/oriented x 4, speech clear/understandable
	Cardiovascular	Regular apical pulse, peripheral pulse palpable. No significant peripheral edema
	Pulmonary	CTA. Respirations regular, unlabored. Nail beds & mucous membranes pink/moist
	Integumentary	Skin color normal. Skin warm, dry & intact
	Musculoskeletal	Moves all extremities. No muscle weakness
	Emotional Status	❑calm ❑anxious ❑agitated ❑withdrawn
	Psychosocial	❑pediatric (14-18 years) ❑adult ❑geriatric
	Airway	Neck has full ROM, jaw/mouth moves freely and opens wide

❑ Patient acknowledges understanding of procedure

❑ Procedure & discharge instructions reviewed with patient

Patient accompanied by _____

IV catheter: ❑20g ❑22g ❑24g ❑n/a

site_____ # attempts_____ by_____

1% intradermal xylocaine used? ❑yes ❑no

❑500ml NSS ❑saline lock ❑NA ❑other_____

additional medication given? ❑yes ❑no

medication name: _____

dose administered_____ time_____

route_____ initials_____

Additional Nursing Comments: _____

Signature(s) / initials: / , /

Norman Endoscopy Center

Medication/Allergy Reconciliation Record
Discharge Instructions

Patient Label

Allergies/Sensitivities & Reactions			
❑ **NKA (No Known Allergies)**		Name	Reaction
Egg / Soy Allergy ❑ yes ❑ no	Reaction	Name	Reaction
Latex Allergy ❑yes ❑ no	Reaction	Name	Reaction
Name	Reaction	Name	Reaction
Name	Reaction	Name	Reaction

Date Last Taken	**Medication History** (Include herbals & over the counter medications) **herbal products are not included in directions for continuation of home medications** **Medication Name** **Dose/Frequency**

I have reviewed the Medication/Allergy list and verify that it is a complete list of my current medications and allergies.
Patient Signature _____ Date _____

( ) Medication History continues on page 2

(this section for office use only)

Signature Review of Medications and Allergies across the patient care continuum

Pre-op _____ Intra-procedure _____ Discharge _____

Medications/Allergies/Medical History/Pre-procedure Nursing Assessment Reviewed:

CRNA Signature (if applicable) _____

Physician Signature: _____

Medication/Allergy History obtained from:
❑ Patient ❑Spouse ❑Guardian ❑Other _____
❑ Information obtained from previous medical record dated _____

Interviewer _____ Date _____