Norman Endoscopy Center Patient Registration Information

Date of Procedure			NEC Physician: Primary Care Physician:				
Time of Procedure	2:		Primary Care Physician:				
Patient Name:							
	(last name)	(first name	e) (middle initial)	(suffix)			
Mailing Address: _	(street address)		(state)	(zip code)			
Telephone:			Emergency Contact:				
		_(cell)	Emergency Contact telephon	le:			
		_(work)	Email Address:				
Date of Birth:							
Gender:	male 🗌 female	\Box other					
Do you have any H	lispanic origin?	□ yes ¯	$ \begin{array}{c c} \hline \Box no & \Box unknown \\ ved & \Box divorced & \Box life partner \end{array} $				
Marital Status:	single 🗆 married	l 🗆 widov	ved \Box divorced \Box life partner				
Insurance Information (please bring insurance cards to appointment)							
Primary Insurance:		<u></u> (p	Secondary Insurance:				
Subscriber ID:			Subscriber ID:				
Group Number:			Group Number:				
Policy Holder's Name	2.		Policy Holder's Name:				
Relationship to the pa	atient:		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

Authorization

AUTHORIZATION & INFORMATION TO BE SHARED

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

I hereby request payment of medical b	anafitata Namaan Endagaan	. Camban ba ha main dinaab	
i nereov request payment of medical p	enerits to Norman Endoscopy	Center, to be baid direct	iv by my insurance company(s).
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ADVANCE DIRECTIVE

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

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:						
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 ______

Patient label

initial

initial

initial

initial

NORMAN ENDOSCOPY CENTER, LLC ENDOSCOPY PRE-PROCEDURE RECORD									par	tient la	abel		_		
Height			Weight	BMI			Male	□ Fem	ale		,				
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		-		D irregular hea	-			nator	2						
								D	3						
High blood pressure:									4 5						
		Stroke: date, list any lasting effects					<u></u>								
		Stomach/colon: □abdominal pain, □dysphagia □IBS					>	6							
		□ulcer, □reflux/GERD/heartburn, □esophageal varices □resection, □ostomy, □diarrhea, □bleeding, □Crohn's □Barrett's esophagus, □nausea/vomiting, □other						/							
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		-		nchitis 🗖 abr					Date of last						
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		-		V, measles,	chickeı	n pox, iı	nfluenz	a?	anesthesia	ı or seda	tion?	🗕 no 🗖	yes,		
		Recent tra	el outside	the US?					List pertine	ent medic	al histo	ry not ac	dressed:		
		Have you ha	nd MRSA, VF	RE, Creutzfiel	d-Jacob	Disease	e <i>(aka l</i>	Mad Cow))						
		Liver disea	se: 🗆 cirrho	osis, or 🛛 hep	oatitis 🗆	A 🗆 B	ПC								
		Kidney or	Bladder Dise	ease: 🗆 inco	ntinence	e, 🗖 othe	er		Do you use	nicotine	? 🗆 y	ves 🗆] past use	e 🗆 n	ever
		Diabetes:	□oral meds	, 🗆 insulin d	epender	nt, 🗖 die	et contr	olled	Packs/day?		yea	rs of use	e?	age q	uit?
		Abnormal b	leeding: 🗆 k	lood thinners,	Dsickle	e cell tra	it, 🗆 ot	her	Alcohol/rec						
		Cancer: ex	plain type/tr	reatment		Abnormal bleeding: Dolood thinners, Dsickle cell trait, Dother Cancer: explain type/treatment					-		•		
		Epilepsy or Seizure disorder? Explain					Use per day, week, month <i>(circle one)</i> ?								
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Norman Endoscopy Center Medication/Allergy Reconciliation Record Discharge Instructions

	Allergies/Sensit	ivities & Reac	tions						
D NKA (No Ki		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 & ov **herbal products are not included in direction	s for continuation	tinuation 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									
<i>(this section for office use only)</i> Signature Review of Medications and Allergies across the patient care continuum									
Pre-op	Intra-procedure		Discharge						
Medications/Alle Assessment Revi	ergies/Medical History/Pre-procedure Nur ewed:	rsing	Medication/Allergy History obtained from: Patient Spouse Guardian Other Information obtained from previous medical record						
CRNA Signature	e (if applicable)		dated						
			Interviewer Date						
Physician Signat	Physician Signature:								