Date ____________________

Physician ____________________

Patient # ____________________

North Hills
Gastroenterology Endoscopy Center

PATIENT REGISTRATION

Please Print

Referring Physician ______________________________
(Name) (City)

Name ____
(Last) (First) (Middle)

Mailing Address ____
(Street) (City) (State) (Zip Code)

Permanent Address ____
(Street) (City) (State) (Zip Code)

Phone # ____________________ **Cell #** ____________________ **Business Phone #** ____________________

Age ________ **Sex** ________ **Date of Birth** ____________________ **Social Security #** ____________________

Email Address ____

☐ Black/African Am. ☐ Asian ☐ White ☐ Am. Indian, Alaska Native ☐ Native Hawaiian, Other Pacific Islander ☐ Unknown ☐ Declined

Ethnicity (Origin): ☐ Not Hispanic or Latino ☐ Hispanic or Latino Preferred (Primary) Language: ____________________

Please check one ☐ Married ☐ Single ☐ Widowed ☐ Separated

Patient's Employer ______________________________ **Occupation** ____________________

Name of Spouse ____________________ **Social Security #** ____________________ **Date of Birth** ____________
(or Parent)

Spouse's Employer ______________________________ **Spouse's Phone-Cell #** ____________________

Emergency Contact ____________________ **Phone #** ____________________ **Relationship** ____________________

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICE WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

HEALTH INSURANCE INFORMATION

Medicare # ____________________ **Medipak #** ____________________ **AR Medicaid#** ____________________

OTHER MEDICAL INSURANCE

Primary Ins. ______________________________ Address ______________________________

ID # ______________________________ Group # ____________________

Policy Holder's Name ____________________ Phone# ____________________ DOB ____________ SS# ____________________

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other

Secondary Ins. ______________________________ Address ______________________________

ID # ______________________________ Group # ____________________

Policy Holder's Name ____________________ Phone # ____________________ DOB ____________ SS# ____________________

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other

NORTH HILLS ENDOSCOPY PATIENT MEDICATION RECONCILIATION FORM

Please complete the following and BRING BACK on your scheduled procedure date.

Name:	**Date of Birth:**	**Age:**

Allergies: ☐ Yes ☐ No Known Allergies | **Latex Allergy:** ☐ No ☐ Yes ☐ Testing performed for Latex allergy

Allergy (Drug)	**Reaction**	**Allergy (drug)**	**Reaction**

Current Medications

OFFICE USE ONLY

Name of Medications: including Herbals, Vitamins, Supplements & Non-Prescriptive Drugs (**print please**)	**Dose**	**How Often**	**Last Dose Taken Date/Time**	**After Discharge**	
				Continue	**Stop**

Surgical History (Please list **ALL**):____

____

____

____

OFFICE USE ONLY **New Medications or New Dosages you should take after discharge.**

Medication Name/Dose/Route/Frequency	**How was prescription dispensed?**

Nurse Signature:____ **Date:**________________