Please fill out and bring with you day of procedure

# PREMIER ENDOSCOPY

1656 Medical Blvd. Suite 201
Naples, FL 34110

## Registration Form

Patient Name: First________________ Middle__________________ Last_________________________

Date of Birth: ___________________ Circle Marital Status: M S W D

Social Security Number ________-______-___________

Name of Person Taking You Home______________________ Phone No. __________________

For State Statistics, please indicate: 1.__Asian or Pacific Islander 2.__Black 3.__Black Hispanic
4.__White 5.__White Hispanic 6.__Native American/Eskimo/Aleut
7.__Other

Local Address: Street ___________________________________________ Suite / Apt. #: ____________

City________________________ State_________ Zip___________ Home Phone__________________

Alt. Phone______________________

Billing Address (if different):Street___________________________________ City__________________

State_______ Zip__ _________ Phone_______________________

Name of Primary Subscriber of Insurance (if different from patient):_______________________________

Date of Birth ____________________ Social Security Number________-_____-___________

Name of Pharmacy that you use:____________________________________________________________

Pharmacy Address:_______________________________________________________________________

Phone Number______________________________

Referred to our office by:______________________________ Family Doctor:______________________

**Notice of Patient's Rights have been given previously at physician's office [ ] yes**

# PREMIER ENDOSCOPY CENTER

## Medication Reconciliation Form

**(LIST ALL ALLERGIES)**

| Allergic To / Describe Reaction: | Allergic To / Describe Reaction: |
| --- | --- |
| | |
| | |
| | |
| | |

List ALL medications, vitamins, herbal, over the counter, pumps, patches, inhalers, sprays, ointments.

| Medication Name | Dose | Frequency (How Often) | Indication (Reason) | Medication Taken Today YES | NO |
| --- | --- | --- | --- | --- | --- |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |

**BELOW THIS LINE CENTER USE ONLY**

Source: ☐ Patient ☐ Family ☐ Provided List ☐ History & Physical (PCP) ☐ Other ____________

Admitting Nurse: ______________________

| New Medication Prescribed Following Your Surgery | | |
| --- | --- | --- |
| Medication | Dose / Route / Frequency | Possible Side Effects |
| | | |
| | | |
| | | |
| | | |

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## ADVANCE DIRECTIVES

To comply with state regulations, our facility is required to ask you if you have an Advance Directive. (Living Will)

It is important that you understand that Advance Directives are not intended for use in Ambulatory Centers such as ours. As a matter of conscience and as permitted by Florida State Statute 765.104, regardless of the contents of any advance directive, if an adverse event occurs during treatment we will initiate resuscitative measures. The center will assist with rescheduling the procedure at another facility that will comply with your wishes, if you wish the advance directives to be followed.

Information is available to you, at this facility, on Advance Directives, including living will, durable power of attorney and similar documents addressing your care decisions.

_______________ No, I do not have an Advance Directive.

_______________ Yes, I do have an Advance Directive, and I understand that It will not be honored at this time.

______________________________
Signature of Patient

## RELEASE OF MEDICAL RECORDS

[] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[] Physician______________________________
[] Spouse________________________________
[] Other_________________________________

[] Information is not to be released to anyone

Signature______________________________ Date____________________

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# INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME, TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.
I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature ______________________________
Date ______________