MOUNTAIN VIEW
ENDOSCOPY & SURGERY CENTER

PATIENT REGISTRATION SHEET

Save time. Submit online: www.mtviewsurgery.com/registration

APPOINTMENT DATE: _____ PRIMARY LANGUAGE: _____

FULL NAME: _____ DATE OF BIRTH: _____

MAILING ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____ E-MAIL: _____

AGE: _____ ☐ MALE ☐ FEMALE ☐ NON-BINARY EMPLOYER: _____

PHONE NUMBERS: Home: _____ ( ) OK to leave detailed message

Cell: _____( ) OK to leave detailed message

Work: _____ ( ) OK to leave detailed message

Race: (check one)

☐American Indian
☐Alaskan Native
☐Asian
☐Black
☐African American
☐Native Hawaiian
☐Other Pacific Islander
☐White
☐Other Race
☐Unknown

Ethnicity: (check one)

☐Hispanic
☐Non-Hispanic
☐Other

EMERGENCY CONTACT INFORMATION:

Emergency Contact Person: _____

Relationship to Patient: _____

Contact Person Home Phone #: (____)_____ Cell Phone #: (____)_____

REFERRING PHYSICIAN OR PRIMARY PHYSICIAN INFORMATION:

Referring Physician Name: _____

Address: _____City _____ Zip _____

Office Phone # (_____)_____ Fax Number (_____)_____

**Please remember to bring your photo ID, Insurance cards, and a driver must accompany you to your appointment.*

**By signing, you acknowledge that although your insurance company will be billed for this service, you are ultimately responsible for payment of this account.*

Patient Signature: _____ Date: _____

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Current Medications List

ALLERGIES/SENSITIVITIES:	REACTIONS:

Please list every prescription, over-the-counter, or homeopathic medication you are presently taking. Be sure to include the strength and dosage for each medication, and how often it is taken. Please complete this form prior to your procedure and bring it with you to your appointment. Thank you.

Name of Medication and Dosage	Reason for taking medication	How often do you take this medication	Last Taken (For Nurse Use Only)
Example: Metformin 500 mg (1) tablet	Control Type 2 diabetes	Twice a day, AM & PM	

For office use

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Patient History

Name:_____ Date of Birth: _____

Reason for procedure:_____

Could you be pregnant? ☐ No ☐ Yes Would you like a pregnancy test? ☐ No ☐ Yes

Have you had any of the following within the past 6 months? (check all that apply)

☐ Chest Pain ☐ Shortness of Breath ☐ Stroke ☐ Blood Clot ☐ Seizures

☐ Coronary Stent Placement

Have you had any adverse reaction to anesthesia or sedation?

☐ No ☐ Yes, please describe: _____

Do you use supplemental oxygen? ☐ No ☐ Yes

Do you use a CPAP machine at night? ☐ No ☐ Yes

Do you have a defibrillator and/or pacemaker? ☐ No ☐ Yes

Do you have any medical problems (such as diabetes, high blood pressure, etc.)?

_____

_____

_____

Have you had any surgeries/procedures (including colonoscopy and upper endoscopy) in the past? If so, when?

_____

_____

_____

Do you use any of the following? (check all that apply):

☐ Tobacco ☐ Marijuana ☐ Alcohol ☐ Illicit Drugs

Has any family member been diagnosed with cancer of the esophagus, stomach, liver, pancreas, or colon? ☐ No ☐ Yes

If yes, what is their relation to you and at what age were they diagnosed?

_____

_____

Signature: _____ Date: _____

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