Endoscopy Center of North Baltimore LLC (ECNB)

1220 East Joppa Road, Building C, Suite 508, Towson, MD 21286

(P) 410-296-4415 (F) 410-296-4417

PLEASE FILL OUT COMPLETELY PRIOR TO YOUR PROCEDURE

PATIENT NAME_____

STREET ADDRESS_____

CITY _____ STATE_____ ZIP_____

PHONE_____ CELL PHONE_____ DOB_____
AGE_____SEX_____

MARITAL STATUS_____ SOCIAL SECURITY #_____

EMPLOYMENT STATUS ☐ FT ☐ PT OCCUPATION_____

EMPLOYER_____ EMPLOYER PHONE_____

EMPLOYER ADDRESS_____

CHIEF COMPLAINT_____PROCEDURE DATE_____

GI DOCTOR_____ PRIMARY DOCTOR_____

NAME OF PERSON TAKING YOU HOME_____

CONTACT NUMBER_____

INSURANCE INFORMATION – PRIMARY

TYPE OF INSURANCE_____

POLICY HOLDER_____

RELATIONSHIP TO PATIENT_____

POLICY ID #_____ GROUP #_____

POLICY HOLDER SS #_____ POLICY HOLDER DOB_____

SEONDARY INSURANCE-TYPE_____

POLICY HOLDER_____

RELATIONSHIP TO PATIENT_____

POLICY ID #_____ GROUP #_____

POLICY HOLDER SS #_____ POLICY HOLDER DOB_____

Please answer YES or NO to the following disorders and give any explanation necessary

Disorder	Yes	No	Disorder	Yes	No
High Blood Pressure			Infectious Diseases/ Other		
Heart Attack/Angina			Breast Cancer		
Congestive Heart Failure			Diabetes		
Heart Murmur/ Mitral Valve Prolapse			Glaucoma		
Valve Replacement/Endocarditis			Back/ Neck Problems		
Cardiac Surgery/ Stents			Any Joint Replacements		
Irregular Heartbeat			Arthritis		
Kidney Disease/ Renal Failure			Epilepsy		
Bladder Problems			Bleeding Disorders/ Anemia		
Thyroid Problems			Stomach Ulcer		
Internal Defibrillator/Pacemaker			Reflux/Esophagitis		
Stroke			Esophageal Stricture		
Lung Disease/ Tuberculosis/ Other			Barretts Esophagus		
Sleep Apnea/ CPAP/ Home Oxygen			Hiatal Hernia		
Asthma/ Emphysema/ COPD			Family History of Colon Cancer		
Liver Disease/ Hepatitis/ Other			Bowel Surgery/ Colon Cancer		
Polyps/ Colon Polyps			Ostomy		
Hemorrhoids			Diverticulosis/Diverticulitis		
Crohn's Disease/ Ulcerative Colitis			Diarrhea/C-Diff		
Irritable Bowel/ Spastic Colon			Other		

Any Past Major Surgeries:

_____

_____

Any Medication Allergies:

_____

_____

Are you Allergic to Latex or Contrast (IVP Dye): _____

(Female Only) Are you Pregnant? _____

Any Past Issues with Anesthesia?

_____

_____

On a scale of 1-10 (with 0 being no pain and 10 being very severe) how would you define your level of pain? _____

Do you have any Advance Directives currently in place? ☐ **Yes** ☐ **No**

PLEASE LIST ALL YOUR CURRENT MEDICATIONS. INCLUDE ALL OVER THE COUNTER MEDICATIONS (VITAMINS/HERBAL) TAKEN ON A REGULAR BASIS. INCLUDE IF YOU TAKE ASPIRIN OR IBUPROFEN OF ANY KIND

NAME OF MEDICATION	DOSE AND ROUTE	FREQUENCY	LAST DOSE

HEIGHT _____ WEIGHT _____

Check if you use any of the following

Alcohol ☐ Yes ☐ No Quantity Per Day_____

Tobacco ☐ Yes ☐ No Quantity Per Day_____

Narcotics ☐ Yes ☐ No Quantity Per Day_____

You will be called 24-72 hours post-procedure. If you are unavailable, may we leave a voicemail or speak with another party at that number? Yes ☐ No ☐

DISCLAIMER

By printing and/or signing this form, you acknowledge that the Endoscopy Center of North Baltimore has allowed you full access to all forms of disclosure required by Maryland State Law, and by any and all organizations requiring various types of disclosure to include, but not limited to, a patient's bill of rights, our policy on advance directives, a statement of disclosure of ownership by out doctors, a list of credentials for each of our doctors, etc. A full list of our current forms of disclosure can be found at https://gastrohealth.com/locations/towson. Each doctor's individual credentials can be found at the "credentials" link on https://gastrohealth.com/locations/towson.

_____ _____ _____

Patient Signature Signature of Reviewing RN Date