Procedure Scheduling Form

Date:_______________ Doctor:_________________ Account:________________

Please fill in all information listed below to assure your appointment is scheduled for your convenience and all major health issues are taken into consideration for safety of your preparation prior to the procedure.

YOU ARE SEDATED FOR THESE PROCEDURES AND WILL NEED SOMEONE TO DRIVE YOU HOME AFTERWARD.

Patient:_____________________________________ DOB:____________________

Procedure will be performed at Southern Indiana Endoscopy unless we do not participate with your insurance plan.

Schedule procedure on: Monday Tuesday Wednesday Thursday Friday Any

Is there any specific date(s) not good for you?___________________________________

Are you a diabetic? yes no

If yes, controlled by: Diet

Medicine

Name: ____

Dosage____

Insulin - dosage____

Do you take medications for: Arthritis ______________________________

Heart disease _________________________

Blood thinner _________________________

Do you have an artificial heart valve? yes no

If yes, do you receive antibiotics prior to dental work or surgery? yes no

Do you have a pacemaker? Yes no

If yes, list brand and model____

Do you have a personal history of cancer?______________________________________

Please be aware that if a procedure needs to be rescheduled it could take up to 4-6 weeks depending on the physicians' schedules. We appreciate and encourage that you make every effort to keep your appointment.