PLEASE FILL OUT ENTIRE FORM

Patient's Name: ______________________________ TODAY'S DATE: ______________
Date of Birth (DOB): ______________ Current Age: ______________ Sex: ☐ MALE ☐ FEMALE
Address: ______________________________ City, State & Zip: ______________________________
Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed SSN: __________-__________ - __________
Spouse's Name: ______________________________ DOB: __________ Phone #: ______________

Family Doctor/PCP: ______________________________ ALLERGIES: ______________________________

May we leave a message: On your voicemail/answering machine ☐ No ☐ Yes Via Text Message: ☐ No ☐ Yes
Via Email ☐ No ☐ Yes If yes, email address: ______________________________

Employer / School: ______________________________ Occupation: ______________________________

WHO CAN WE SPEAK TO REGARDING YOUR MEDICAL CONCERNS / HISTORY?

Name: ______________________________ Relationship: ______________
Name: ______________________________ Relationship: ______________
Name: ______________________________ Relationship: ______________
Name: ______________________________ Relationship: ______________

EMERGENCY CONTACT: (phone # must be different than patient's phone #)

Name: ______________________________ Phone #: ______________ Relationship: ______________

Responsible Party for Insurance & Medical Bills: ☐ Patient ☐ Spouse ☐ Parents ☐ Mother ☐ Father ☐ Other

Primary Insurance Company: ______________________________
Subscriber Name: ______________________________ Subscriber DOB: ______________
Insurance ID #: ______________________________ Insurance Group #: ______________
Relationship to Card Holder: ☐ Self ☐ Spouse ☐ Dependent Card Copied: ☐ YES ☐ NO Co-Payment: $__________

Secondary Insurance Company: ______________________________
Subscriber Name: ______________________________ Subscriber DOB: ______________
Insurance ID #: ______________________________ Insurance Group #: ______________

FOR MINORS ONLY

Child lives with: ☐ Both Parents ☐ Mother ☐ Father
Mother / Guardian: ______________________________ Date of Birth: ______________
Address (street, city, state & zip – if different): ______________________________
Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________
Father: ______________________________ Date of Birth: ______________
Address (street, city, state & zip – if different): ______________________________
Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

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powered by

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PLEASE COMPLETE THIS QUESTIONNAIRE WITH UPDATED INFORMATION & RETURN TO OUR OFFICE

Date: ______________ Last Name of Provider at Digestive Disease Consultants: ____________________________

Patient Name: ____ DOB: ____________________

Address: ____

Best Phone # to Reach You: ☐ HOME ______________________________ ☐ CELL ______________________________

Name of Family Doctor / PCP: ____

List of Medications (both prescriptions & over the counter)

Medication Allergies: ☐ NONE ☐ YES: ____

____

____

Do you have an Internal Defibrillator or Pacemaker? ☐ NO ☐ YES

Are you on any blood thinners? ☐ NO ☐ YES *Name of Doctor Managing Blood Thinners: ____________________

(Examples: Coumadin, Heparin, Plavix, Vitamin E, Pradaxa, Eliquis, Zarelto, Brillinta, Warfarin)

Are you taking **Aspirin**? ☐ NO ☐ YES Are you taking **iron pills**? ☐ NO ☐ YES

If you are on the above medications, you may need to discontinue prior to your procedure.

Any new surgeries or new medical illness since your last visit with one of our providers? ☐ NO ☐ YES

If yes: ____

Primary Medical Insurance (Provider & ID #): ____

Secondary Medical Insurance (Provider & ID #): ____

Do you need a referral? ☐ NO ☐ YES (If yes, please contact your primary care provider.)

Please Note: Aetna HMO & Tricare Prime require a referral.

Once your paperwork has been received and reviewed by your provider, WE WILL CONTACT YOU TO SCHEDULE your procedure and appointment to pick up your prep and instructions. (Please allow 20 minutes for this appointment.)

OFFICE USE ONLY

Schedule Date: ____________________ Time: _______________ Location: _________________________

Doctor Indications: ____

____

TO SIGN MA: _______________________ NURSE VISIT: ____________________________

Patient Name & DOB: ______________________________ Today's Date: __________

(Please make sure your Name, DOB & Today's Date are listed above.)

Pharmacy Name: ______________________________

Pharmacy City: ______________________________ Pharmacy Phone #: ______________________________

Do you have a mail order prescription program? ☐ NO ☐ YES If YES, with whom? ______________________________

Allergies: ______________________________

Please list all prescribed medications, including vitamins and over-the-counter.

MEDICATION	PRESCRIBED BY	DOSE	HOW MANY TIMES PER DAY	REASON