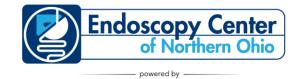


🛈 One**Gl**



(C) One**GI**

PLEASE FILL OUT ENTIRE FORM

Patient's Name:								IODA	Y'S DATE:	
Date of Birth (DOB):				Current Age	e:			Sex:		
Address:						City, S	itate & Zip: _			
Home Phone:										
Marital Status:										
Spouse's Name:						DOB:		Phone #:		
Family Doctor/PCP	:					ALLERG	IES:			
May we leave a me	ssage:		cemail/answerin No □Yes					Via Text Messag		
Employer / School:						-	Occupatio	on:		
WHO CAN WE SPI	FAK TO R	FGARDING			S / HISTO	ORY?				
								Relationship:		
N1								•		
N1										
Name: Responsible Party			al Bills: 🗆 Patier							
Primary Insurance (
Subscriber Name:	company:)R·	
Insurance ID #:										
Relationship to Car	d Holder:	□ Self □ S _l	pouse 🗆 Depe	endent C	Card Cop	ied: 🗆 Y				
Secondary Insuranc	e Compar	יy:								
Subscriber Name:								_ Subscriber DC)B:	
Insurance ID #:	Insurance Group #:									
FOR MIN	ORS C)NLY								
Child lives with:	🗆 Both Pa	arents 🗆 Mo	other 🗆 Father	r						

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:	



1299 Industrial Parkway North, Ste 110 Brunswick, OH 44212

> 3985 Medina Road, Ste 120 Medina, OH 44256

500 East Royalton Road, Ste 100 Broadview Heights, OH 44147

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

OneGl

Date:	Last Name of F	Provider at Digestive [Disease Consultants:
Patient Name:		-	
Address:			
Best Phone # to Reach Y	′ou: □ HOME		
Name of Family Doctor ,	/ PCP:		
List of Medications (both	n prescriptions & over t	he counter)	
Medication Allergies: 🗆 🛚	NONE 🗆 YES:		
Do you have an Interna	l Defibrillator or Pacer	maker? □NO □Y	′ES
			Managing Blood Thinners: Zarelto, Brillinta, Warfarin)
Are you taking Aspirin? ***If you are on the abov		, 0	pills?
Any new surgeries or ne		-	one of our providers? □ NO □ YES
Primary Medical Insuran	ce (Provider & ID #):		
Do you need a referral?	□ NO □ YES (If yes, p	olease contact your pr	rimary care provider.)
Please Note: Aetna HMC	D & Tricare Prime requi	re a referral.	
			ider, WE WILL CONTACT YOU TO SCHEDULE your Please allow 20 minutes for this appointment.)
		OFFICE USE (
Schedule Date:		Time:	
Doctor Indications: _			

TO SIGN MA:

Bipin Sharma, MD, MRCP (UK)

David Myers, MD

Fadi Bashour, MD

Richard Del Rio, MD, MS, MBA

Maya Merheb, MD

NURSE VISIT:

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

Today's Date: _____

Pharmacy Name: Pharmacy City:

Pharmacy Phone #: _____

Do you have a mail order prescription program?
ON OVER NO VES IFYES, with whom?

Allergies: _____

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

MEDICATION	PRESCRIBED BY	DOSE	HOW MANY TIMES PER DAY	REASON