Digestive Disease Consultants

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Welcome to Our Practice!

Please fill out the information found below to the best of your ability.

Date of Birth _____ Physician _____ Today's Date _____

Patient Name _____

Why are you here today? _____

Patient Medical History

Have you ever had the following? (Check no, yes, or leave blank if uncertain.)

Arthritis	☐ No	☐ Yes	Plasma Transfusions	☐ No	☐ Yes	Mitral Valve Prolapse	☐ No	☐ Yes
Anemia	☐ No	☐ Yes	Blood Transfusions	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Epilepsy	☐ No	☐ Yes	Low Blood Pressure	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes
High Blood Pressure	☐ No	☐ Yes	Hemorrhoids	☐ No	☐ Yes	Peptic Ulcer Disease	☐ No	☐ Yes
Migraine Headaches	☐ No	☐ Yes	Asthma	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes
Tuberculosis	☐ No	☐ Yes	Heart Attack	☐ No	☐ Yes	Overactive Thyroid	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Stents Placed	☐ No	☐ Yes	Underactive Thyroid	☐ No	☐ Yes
Cancer	☐ No	☐ Yes	AIDS or HIV+	☐ No	☐ Yes	Bleeding Tendency	☐ No	☐ Yes
If yes, what kind? _____			Infectious Mono	☐ No	☐ Yes	Any Other Disease	☐ No	☐ Yes
Polio	☐ No	☐ Yes	Atrial Fibrillation	☐ No	☐ Yes	Please list other: _____		
Glaucoma	☐ No	☐ Yes	Sleep Apnea	☐ No	☐ Yes			
Hiatal Hernia	☐ No	☐ Yes	Use CPAP	☐ No	☐ Yes			
Inguinal Hernia	☐ No	☐ Yes	Defibrillator	☐ No	☐ Yes			
Incisional Hernia	☐ No	☐ Yes	Pacemaker	☐ No	☐ Yes			

Previous Surgeries / Serious Illnesses	When	Hospital, City, State / Province

When / Where was your last upper endoscopy? _____

When / Where was your last colonoscopy? _____

Patient Social History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: _____ Number of Children: _____

Alcohol Use: ☐ Never ☐ Occasionally – Drinks per Week _____ ☐ Daily – Drinks per Day _____

Tobacco Use: ☐ Never ☐ Previously, but Quit – Packs per Day _____ ☐ Currently – Packs per Day _____

When Did You Last Smoke? _____ (month and year)

Illegal Drug Use: ☐ No ☐ Yes, Type & Frequency _____

Family Medical History

Any Family Medical History of: ☐ Colon Cancer ☐ Stomach Cancer ☐ Peptic Ulcer Disease ☐ Irritable Bowel Syndrome ☐ Colon Polyps ☐ Diverticulitis ☐ Ulcerative Colitis ☐ Celiac Disease

Illness or Cause of Death:

Father _____

Mother _____

Brother _____

Sister _____

Spouse _____

Children _____

Other _____

Patient Name & DOB: _____ Today's Date: _____

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

Review of Systems: Please indicate any personal history below.

CONSTITUTIONAL	YES	NO
Weight Loss		
Fever		
Fatigue		

RESPIRATORY	YES	NO
Chronic Cough		
Spitting Up Blood		
Wheezing		
Snoring		

CARDIOVASCULAR	YES	NO
Chest Pain		
Shortness of Breath		
Swelling in Ankles		

GI	YES	NO
Difficulty Swallowing		
Heartburn		
Nausea		
Vomiting		
Bloating		
Belching		
Regurgutation		
Constipation		
Diarrhea		
Abdominal Pain		
Rectal Bleeding		
Rectal Pain		
Poor Appetite		

GENITOURINARY	YES	NO
Possibility of Pregnancy		
Blood in Urine		
Currently Breastfeeding		
Burning with Urination		
Incontinence of Urine		
Irregular Periods		

NEUROLOGICAL	YES	NO
Seizures		
Numbness/Tingling		
Weakness		
Headaches		

MUSCULOSKELETAL	YES	NO
Back Pain		
Joint Pain		
Muscle Pain		

ENDOCRINE	YES	NO
Excessive Thirst		
Heat Intolerance		
Excessive Urination		
Cold Intolderance		

PSYCHIATRIC	YES	NO
Depression		
Anxiety / Nervousness		
Confusion		
Memory Difficulty		
Insomnia		

INTEGUMENTARY	YES	NO
Itching		
Rashes		

HEMATOLOGIC / LYMPHATIC	YES	NO
Easy Bleeding		
Easy Bruising		
Anemia		
Sickle Cell Anemia		
Enlarged Glands		
Rejected for Blood or Plasma Donation		

ENMT	YES	NO
Sore Throat		
Hearing Loss		
Ringing in Ears		
Mouth Sores		
Taste Change		
Sore Tongue		

ALLERGIC / IMMUNOLOGIC	YES	NO
HIV Exposure		
Persistent Infections		
Strong Allergic Reaction or Urticaria		

EYES	YES	NO
Loss of Vision		
Blurred Vision		

Known Food Allergies: _____

Environmental Allergies: _____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

SIGNATURE: DATE:

_____ _____

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? _____

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

MEDICATION	PRESCRIBED BY	DOSE	HOW MANY TIMES PER DAY	REASON

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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: _____

Privacy Consent – For the Use & Disclosure of Protected Health Information (PHI)

This consent is required by the Health Insurance Portability & Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to DDC and the Endoscopy Center of Northern Ohio to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize (this practice), and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professional for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take affect until the practice receives it.

Patient / Guardian Signature: _____ Date: _____

Name Printed: _____ If not patient, relationship: _____

Copy of Practice Privacy statement signed or initiated with patient / guardian on: _____

Patient unable to sign privacy statement due to: _____

REVOCATION

I hereby revoke the consent given above:

Patient / Guardian Signature: _____ Date: _____

Name Printed: _____ If not patient, relationship: _____

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Patient / Guardian Initials: _____ Date: _____

Bipin Sharma, MD, MRCP (UK)
David Myers, MD
Fadi Bashour, MD
Richard Del Rio, MD, MS, MBA
Maya Merheb, MD

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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

BILLING POLICY

We now require all deductibles and co-pays be paid prior to or at the time of service.

Any outstanding balances are to be paid in full within a 90-day grace period. All accounts over **90 days old are subject to a monthly interest charge of 1.5%, annual rate of 18%.**

Please make every effort possible to satisfy balances accordingly to avoid accumulating interest and possibly having your account turned over to a collection agency. **Patients who have their accounts turned over to a collection agency are discharged from our Practice and are subject to an additional $25.00 collection fee.**

If you have any questions regarding this policy speak to a member of our Billing Department.

CANCELLATION / NO-SHOW POLICY

At Digestive Disease Consultants and the Endoscopy Center of Northern Ohio, our goal is to serve our patients with quality care in a timely manner. To provide the best care in a timely manner, we must implement a cancellation / no-show policy to ensure availability in the office, as well as in our ambulatory surgical center for our patients who are in urgent need of care.

We ask every patient to be considerate to others and to please cancel an appointment in advance so that another patient can be cared for in a timely manner as there is a high demand for available appointments.

We understand that there are circumstances and emergencies prohibiting early cancellation and thus these circumstances will be considered, and a one-time exception can be granted based on the situation. Otherwise, if you do not cancel within 24-hours of your appointment, you will be subject to a cancellation / no-show fee of $100.00. This fee is not covered by insurance and as a patient of this practice, it will your full financial responsibility.

How to Cancel Your Appointment

To cancel your appointment, please call the Digestive Disease Consultants office at 330-225-6468, Monday-Friday 8:00 AM through 4:30 PM. You can also call our answering service 24-hours a day at 888-445-9932. If you are having problems reaching our staff, please leave a message with your name, date of birth, and your reason for calling.

I have read these policies in full; I understand and agree to the terms of these policies.

Printed Name: _____ DOB: _____

Signature: _____

Date: _____ Time: _____