Digestive Disease Consultants powered by OneGI

Endoscopy Center of Northern Ohio powered by OneGI

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: _____

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: _____

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

Digestive Disease Consultants

powered by OneGI

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

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: _____

Are you taking Ozempic, Mounjaro, Wegovy, or any similar GLP-1 medications: ☐ NONE ☐ YES

(If yes, please list on lines provided.) _____

_____

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, Xarelto, 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.

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, over-the-counter, and as needed.

MEDICATION	PRESCRIBED BY	DOSE	HOW MANY TIMES PER DAY	REASON