

**Patient Registration  
Digestive Disease Consultants &  
Endoscopy Center of Northern Ohio, LLC.**

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ [ ] Male [ ] Female Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Marital status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Allergies: \_\_\_\_\_ Family Doctor (PCP): \_\_\_\_\_

**How may we leave messages:** On your answering machine/voice mail [ ] Yes [ ] No Text Messaging [ ] Yes [ ] No

Email [ ] Yes [ ] NO Email Address: \_\_\_\_\_

Names of who we may we talk to about your medical concerns \_\_\_\_\_

\_\_\_\_\_ Relationship(s) \_\_\_\_\_

Employer/School \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name & Date of Birth: \_\_\_\_\_ Spouse's Employer & Work #: \_\_\_\_\_

\*Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
**\*Someone with a DIFFERENT PHONE NUMBER than yours)\***

\*\*Responsible Party for Insurance and Bills: [ ] Patient [ ] Spouse [ ] Parents [ ] Mother [ ] Father [ ] Other \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Relationship to Card Holder: [ ] Self [ ] Spouse [ ] Dependent Card Copied: [ ] Yes [ ] No Co-payment: \$ \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

\*\*For MINORS ONLY \*\* Child Lives With: [ ] with both parents [ ] Mother [ ] Father

Mother/Guardian: \_\_\_\_\_ Address (if different): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Home/Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Father \_\_\_\_\_ Address (if different) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Home/Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_



**Digestive Disease  
Consultants**

1299 Industrial Parkway North, Ste. 110, Brunswick, OH 44212

PHONE: (877) 891-3636 FAX: 330-225-6534

Dr. Bipin Sharma, Dr. Fadi Bashour, Dr. David Myers, Dr. Richard Del Rio, Dr. Maya Merheb

**Please complete questionnaire with updated information and return to our office**


Date: \_\_\_\_\_ Name of your doctor at Digestive Disease Consultants: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Best phone number to reach you: \_\_\_\_\_ or \_\_\_\_\_

Name of Family Doctor: \_\_\_\_\_

**List Medications** (both prescriptions & over the counter) **SEE BACK SIDE OF THIS PAGE** 

**Medication Allergies:** \_\_\_\_\_ **None:** \_\_\_\_\_

**\* Do you have an Internal Defibrillator or Pacemaker?** [YES] [NO]

**\* Are you on any blood thinners?** (Example Coumadin, Heparin, Plavix, Vitamin E, Pradaxa, Eliquis, Xarelto, Brillinta, or Warfarin [YES] [NO])

If yes, name of doctor who manages blood thinners: \_\_\_\_\_

Are you taking **Aspirin**? [YES] [NO] Are you taking **Iron pills**? [YES] [NO]

**\* If you are on the above medications, you may need to discontinue them prior to your procedure**

**\*Any new surgeries or new medical illness since your last visit with one of our doctors?**

\_\_\_\_\_

Name of your medical Insurance \_\_\_\_\_

Name of 2<sup>nd</sup> Insurance: \_\_\_\_\_

Do you need a referral? [YES] [NO] **If yes, please contact your Primary Care Doctor. Aetna HMO, & Tricare Prime requires a referral**

- **Once your paperwork has been received & reviewed by your doctor, 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: \_\_\_\_\_

Dr.'s Indications: \_\_\_\_\_

\_\_\_\_\_

**TO SIGN – M.A.:** \_\_\_\_\_

**NURSE VISIT:** \_\_\_\_\_

