Dear Patient,

As per the guidelines put forward by Governor DeWine of the State of Ohio, beginning May 1, 2020 our office will proceed with scheduling elective procedures. We have been advised to discuss with patients their safety regarding visits to healthcare facilities. Given these unusual times, we wanted to inform you of the additional measures we are taking to ensure the safest environment possible for our patients and staff.

We the physicians, mid-level providers, nurses, and staff of Digestive Disease Consultants and Endoscopy Center of Northern Ohio consider your safety our most important priority. While we believe our office has always maintained the highest level of safety and sanitation, we have implemented additional protocols out of an abundance of caution in response to COVID-19. Below are a few of these measures:

1 - Every person entering our building is screened for coronavirus exposure, including our own doctors and staff daily. Every person must answer a health questionnaire and have their temperature checked.

2 - Personal Protective Equipment (PPE) such as masks are used throughout our office and endoscopy centers. Further, we have implemented strict policies to ensure that all staff wash their hands frequently and that surfaces in common areas are frequently wiped using disinfectants.

3 - Clinical personnel operating in procedure areas will always use proper PPE.

4 - Equipment used in procedures are sanitized according to strict guidelines, using high level disinfectants / sterilizing techniques.

5 - Our schedules and waiting room furniture have been adjusted to accommodate recommended social distancing measures.

6 - Last, we ask you to help us. If possible, please do not bring someone with you to your office visit unless you require assistance from a family member or friend. In addition, please bring only one person to your procedure. No children younger than 14 years old are allowed in the facility. While we regret that we cannot provide masks to our visitors, we strongly encourage you to wear a mask if you have one (we are in this together, and expect you to respect our staff sensitivity to being exposed through visitors).

We appreciate your patience and confidence in us as we create an environment that is as safe as possible for our visitors and our staff while still providing high quality personalized care. To comply with Governor DeWine's policy please sign this statement below and bring to your appointment. If you have any concerns or questions, please do not hesitate to call our office.

We wish you and your family health during these unprecedented times, and we look forward to seeing and serving you.

Physician’s signature...……..…… Date signed:

Patient's signature...…….. Date signed:

April 2020

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 & 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: Home: _____Cell:_____

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 2nd Insurance:_____

Please Note: We are NOT in network with Molina, Paramount, & Caresource, Buckeye, Ambetter and Allwell

Do you need a referral? [YES] [NO] **If yes, please contact your Primary Care Doctor. Aetna HMO, Humana 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:**_____

PATIENT NAME:	PHARMACY NAME:
PHARMACY NUMBER:	PHARMACY CITY:

DO YOU HAVE A MAIL ORDER PRESCRIPTION PROGRAM? **YES** **NO**

IF YES WITH WHOM: _____

TODAY'S DATE:_____ PLEASE LIST ALL PRESCRIBED MEDICATIONS INCLUDING VITAMINS & OVER-THE COUNTER

Name of Medication	Prescribed by	Dose	How many times a day taking	Why taking

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

PLEASE FILL OUT ENTIRE FORM

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

Family Doctor (PCP): _____ **ALLERGIES** _____

How may we leave messages: On your answering machine/voice mail : [ ] YES [ ] NO Text Messaging: [ ] YES [ ] NO

Email: [ ]YES [ ] NO **Email Address:** _____

Employer/School _____ **Occupation:** _____

Spouse's Name & Date of Birth: _____ **Spouse's Phone:** _____

WHO CAN WE SPEAK TO REGARDING YOUR MEDICAL CONCERNS?

1. _____ **Relation:** _____ 2. _____ **Relation:** _____

3 _____ **Relation:** _____ 4. _____ **Relation:** _____

***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:** _____