Submit by Email to DMS Print Form

Scheduling for Office Visit – Digestive Medical Services, Inc.

☐ **INITIAL CONSULTATION** ☐ **FOLLOW UP VISIT**

Laurence Entsuah MD (Board Certified: Internal Medicine & Gastroenterology)

Name: _____ Insurance: _____
Address: _____ ID #: _____
_____ Group #: _____
Age _____ Gender: M ☐ F ☐ Date of Birth: _____
Tel #: (Home) _____ (Work) _____ (Cell) _____ SS# _____
Family Physician / Referring Physician _____

OFFICE LOCATIONS

☐ Digestive Med. Serv. Inc
1418 Brice Rd Site 201
Reynoldsburg OH 43068
614-834-9929
Friday morning

☐ Digestive Med. Serv. Inc
477 Cooper Road Suite230
Westerville OH 43081
614-834-9929
Wednesday afternoon

☐ Digestive Med. Serv. Inc
1458 Sheridan Dr, Suite 100A
Lancaster OH 43130
740-681-9575
Monday afternoon

Preferred date for appointment: _____ Time: _____ Arrive: 15 minutes before time

Disease / Symptoms

☐ Colon cancer ☐ Blood in stool ☐ Hepatitis ☐ Occult bleeding
☐ Colon polps ☐ Diarrhea ☐ Abdominal Pain ☐ Hemorrhoids
☐ Fhx colon cancer or polyps ☐ Anemia ☐ Weight loss ☐ R/o small bowel tumor
☐ Crohn's disease ☐ Change in bowel habits ☐ Nausea/vomiting ☐ Fecal incontinence
☐ Ulcerative Colitis ☐ Abnormal imaging ☐ Difficulty swallowing ☐ Hiatal hernia
☐ Abdominal pain ☐ Diverticulitis ☐ Gastritis ☐ Peptic ulcer
☐ Colitis ☐ Loss of appetite ☐ Flatulence ☐ Constipation
☐ Bloating ☐ Pancreatitis ☐ Gallstone ☐ Lactose intolerance
☐ Irritable bowel syndrome (IBS) ☐ Heartburn/Acid Reflux (GERD) ☐ Barrett's esophagus

MEDICAL DATA:

Height _____ Weight _____ ☐ **lbs** / ☐ **Kg** BMI _____

	YES	NO
Need for prophylactic antibiotics for dental work	☐	☐
Mitral Valve Prolapse	☐	☐
Pacemarker	☐	☐
Defibrillator / AICD	☐	☐

Sleep Apnea with C-PAP or BiPAP ☐ ☐ Pressure settings: _____

Medications:

☐ Coumadin ☐ Plavix ☐ Daily Aspirin/NSAIDS **stop it 3 days before the procedure**

☐ Iron - **Stop it 7 days before colonoscopy**

☐ Insulin and other diabetic medications - **Do not take them the morning of the procedure**

☐ Hypertension or high blood pressure medications - **Please take them the morning of the procedure**

☐ Medications_____

_____

☐ **Allergies**_____

Previous Surgeries:

Previous colonoscopy: Month: _____ 19___ / 20 ___

Previous endoscopy: Month: _____ 19___ / 20 ___

☐ Gallbladder ☐ Hysterectomy ☐ Bladder suspension ☐ Kidney surgery

☐ Prostate surgery ☐ Transplant surgery ☐ Endometriosis surgery ☐ Hernia Repairs

☐ Surgeries: _____

☐ Medical history**:**

_____

_____

Additional information:_____

_____

_____

_____

Best time to contact you _____

Best Phone number to reach you at: _____

IMPORTANT REMINDERS:

Please note you will be seeing a specialist and there may be some waiting time for all of our patients. **You are expected to pay your co-pay in full at each visit and the specialist co-pay may be higher than at your primary care physicians office. Your health insurance provider expects us to collect the copay. Deductibles will be collected if applicable.**

If you cannot keep your appointments please notify us 24 hours in advance or you will be charged a fee of $50.00 for office visit and $80.00 for procedures. Please no food or drinks in the office. Thank you!

AFFILIATIONS:

Medical Group of Ohio (MGO Ohio)

Ohio Health Group _____ Eastside Surgery Center or Grant Hospital

NGS – OSU _____ Knightsbridge Surgery Center

Mount Carmel Health Partners _____ St Ann's Hospital

Fairfield Medical Center _____ Fairfield Medical Center