



PATIENT DEMOGRAPHICS

Date _____ Patient Name _____ DOB _____ Male/Female/Other _____
 Cell Phone _____ Home Phone _____ E-mail _____
 Patient Address _____
 Referring Doctor _____ Phone _____ Fax _____
 Insurance _____ Person Completing Form _____

Providing the home address and/or email will help us reach the patient if unavailable by phone.

PHYSICIAN & LOCATION PREFERENCE

Preferred Physician (select from right)

Urgent

1st Available (choose below)

- Any
- 1st Available Male
- 1st Available Female

- | | |
|--|---|
| <input type="checkbox"/> Teresa Patrick , M.D. | <input type="checkbox"/> Nagaraja Oruganti , M.D. |
| <input type="checkbox"/> Narayan Peddanna , M.D. | <input type="checkbox"/> Urmee Siraj , M.D. |
| <input type="checkbox"/> Rajkamal Jit , M.D. | <input type="checkbox"/> Kanan Sharma , M.D. |
| <input type="checkbox"/> Bikram Verma , M.D. | <input type="checkbox"/> Tristan Handler , M.D. |
| <input type="checkbox"/> Malay K. Dey , M.D., Ph.D. | <input type="checkbox"/> Cassandra Steimle , D.O. |
| <input type="checkbox"/> Christopher Barde , M.D. | <input type="checkbox"/> Michael Sherman , M.D. M.S. |
| <input type="checkbox"/> Jigna Thakore , M.D. | Hospitalists: |
| <input type="checkbox"/> Salma Akram , M.D. | <input type="checkbox"/> Mustafa Musleh , M.D. |
| | <input type="checkbox"/> Jonathan Kushner , M.D. |

Preferred Location Dayton (North) Huber Heights Springboro Sugarcreek Township (Dayton)
 1530 Needmore Rd 5697 Shull Rd 77 W. Eleanor Rd 4340 Clyo Rd

APPOINTMENT TYPE

Screening Colonoscopy

Routine, without GI Symptoms

Colonoscopy – with GI symptoms

Reason: _____

EGD – with consult without consult

Reason: _____

G-Tube Removal/Replacement

Consultation for Evaluation/Treatment

Reason: _____

- EUS – with consult without consult
- Esophageal Motility – with consult without consult
- Anorectal Motility – with consult without consult
- Hemorrhoid Banding
- FibroScan – with consult without consult

Reason: _____

PLEASE FAX LAST OFFICE VISIT, LABS, RADIOLOGY & OTHER TESTS TO 937-297-2203

FAXED YES NO N/A

Digestive Specialists staff will complete the section below:

Scheduled with _____ Appointment Location _____
 Appointment Date _____ Appointment Time _____
 Date faxed to referring Dr. _____ Labs Received Yes No
 Patient # _____ Scheduler _____