Cleveland Gastroenterology Associates, P.A.

Patient Name_______________________________ Acct#_____________________ DOB________________

What pharmacy do you use?____

MEDICATION DOSAGE/FREQUENCY	DATE	DATE	DATE	DATE
I hereby certify that the above information I have provided is true and accurate to the best of my knowledge.	Patient Initials ___________	Patient Initials ___________	Patient Initials ___________	Patient Initials ___________

MEDICATION ALLERGY	REACTION	MEDICATION ALLERGY	REACTION