Cleveland Gastroenterology Associates, P.A.

Patient Name_____Acct#_____DOB_____

What pharmacy do you use?_____

MEDICATION **DOSAGE / FREQUENCY** (Please list medication, strength and dosage below)	DATE of Visit ----------	DATE of Visit ----------	DATE of Visit ----------	DATE of Visit ----------
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