Dayton Gastroenterology, Inc.

(937) 320-5050
(800) 341-5055
www.daytongastro.com

Patient Information - Please Print

Patient Information

Name *(First, Middle, Last)* _____ Date of Birth_____ ❑ Male ❑ Female

Street Address _____ Apt. No._____

City_____ State_____ Zip Code _____ Social Security No. _____

Phone *(check which you prefer)* ❑ Home_____ ❑ Cell _____ ❑ Daytime _____

E-mail Address _____

Employer Name _____

Employer Address _____ Employer Phone _____

Race *(select one)* ❑ White ❑ Black/African Am. ❑ Asian ❑ Hispanic/Latino ❑ Hawaiian/Pacific Islander ❑ Other_____
❑ American Indian/Alaska Native

Preferred Language (select one) ❑ English ❑ Other _____

Ethnicity (select one) ❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Unknown ❑ Other _____

Primary Care Physician _____ Phone _____

Privacy Information: Besides you, with whom may we discuss your medical information?

Name _____ Relationship_____

Cell Phone_____ Home Phone _____

Emergency Contact Name *(if different than privacy contact)*_____ Relationship _____

Cell Phone_____ Home Phone _____

Insurance Information

If you have Medicare:
Are you or your spouse employed? ❑ Yes ❑ No If yes, do you or your spouse have insurance through your employer? ❑ Yes ❑ No

Primary Insurance Policy Holder Name_____ Social Security No. _____

Date of Birth _____ ❑ Male ❑ Female Relationship to Patient_____

Street Address _____ Apt. No._____

City_____ State_____ Zip Code _____ Phone _____

Insurance Name _____ Insurance Address_____

Policy No. _____ Group No. _____

Secondary Insurance Policy Holder Name_____ Social Security No. _____

Date of Birth _____ ❑ Male ❑ Female Relationship to Patient_____

Street Address _____ Apt. No._____

City_____ State_____ Zip Code _____ Phone _____

Insurance Name _____ Insurance Address_____

Policy No. _____ Group No. _____

I hereby authorize Dayton Gastroenterology, Inc. and/or Dayton Gastro Endoscopy Centers to use, access and/or disclose my health information to carry out my treatment, obtain payment and conduct healthcare operations. I acknowledge that I am consenting to receiving care via Video Visit. The scope of care will be at the sole discretion of the health services provider who is treating me, with no guarantee of diagnosis, treatment, or prescription. The health services provider will determine whether or not the condition being diagnosed and/or treated is appropriate for a telehealth encounter. I understand this consent is voluntary. I have been informed that Dayton Gastroenterology, Inc. and Dayton Gastro Endoscopy Centers have a Notice of Privacy Practices, which fully describes how they will use and disclose my health information and that a copy of this is posted in the waiting room and that there are copies available for my review. I understand that the Physicians of Dayton Gastroenterology, Inc. and/or Dayton Gastro Endoscopy Centers have a financial interest in the Dayton Gastro Endoscopy Centers, and that I have the option to choose another healthcare facility for my procedures. I hereby authorize payment of medical benefits that are billed to my insurance to Dayton Gastroenterology, Inc. and/or Dayton Gastro Endoscopy Centers. Western Ohio Sedation Associates, LLC will be providing anesthesia services, and I hereby authorize payment of medical benefits that are billed to my insurance and understand I will be billed separately for their services. I accept responsibility for payment for services provided to me that are not covered by my insurances. By providing the information on this form I am authorizing you to contact me at the phone numbers and address I have provided and/or speak with persons that I have provided to Dayton Gastroenterology, Inc.

Signature *(Patient or Guardian)* **Date**