

**Patient Information – Please Print**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  MALE  FEMALE

Street Address: \_\_\_\_\_ Apt. No.: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Phone (check which you prefer):  Cell: \_\_\_\_\_  Home: \_\_\_\_\_  Daytime: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

Race (select one)  White  Black/African Am.  Asian  Hispanic/Latino  Hawaiian/Pacific Islander  
 American Indian  Other \_\_\_\_\_

Preferred Language (select one)  English  Other: \_\_\_\_\_

Ethnicity (select one):  Hispanic/Latino  Non-Hispanic/Latino  Other: \_\_\_\_\_

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

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell: \_\_\_\_\_ Home: \_\_\_\_\_

Emergency Contact Information (if different than privacy contact)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell: \_\_\_\_\_ Home: \_\_\_\_\_

*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: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  MALE  FEMALE

Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt. No.: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Insurance Address: \_\_\_\_\_

Policy No.: \_\_\_\_\_ Group No.: \_\_\_\_\_

Secondary Insurance Policy Holder Name: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  MALE  FEMALE

Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt. No.: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Insurance Address: \_\_\_\_\_

Policy No.: \_\_\_\_\_ Group No.: \_\_\_\_\_

I hereby authorize Dayton Gastroenterology, Inc. (DG) and/or Dayton Gastro Endoscopy Centers (DGEC) 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 receive care via Video Visit and understand that providers may use artificial intelligence (AI)-assisted technology to help document my visit in my medical record. I understand that my provider reviews and is responsible for all documentation and that my health information is protected in accordance with applicable privacy laws, including HIPAA. I may opt out of AI-assisted documentation by notifying my provider or clinic staff, and doing so will not affect my care. 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 DG and DGEC 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 DG and/or DGEC have a financial interest in the DGECs, 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 DG and/or DGEC, 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 insurance. By providing the information above, I am authorizing you to contact me at the phone numbers and address listed and/or speak with persons that I have listed on this form.

Signature (Patient or Guardian) \_\_\_\_\_ Date \_\_\_\_\_