# PATIENT REGISTRATION

## DEMOGRAPHIC INFORMATION

LAST NAME:_____ FIRST NAME:_____ MI:_____

DATE OF BIRTH: (mm/dd/yyyy)_____

SEX:_____ RACE:_____ SOCIAL SECURITY #:_____ ETHNICITY: _____

ADDRESS 1:_____ ADDRESS 2:_____

CITY:_____ STATE:_____ ZIP:_____

LANGUAGE:_____ LANGUAGE COUNTRY:_____

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ PARTNER ❑ DIVORCED ❑ WIDOWED

PREGNANT: ❑ (Check if applicable) NURSING: ❑ (Check if applicable)

Whom may we thank for referring you to our practice?_____

## CONTACT INFORMATION

HOME PHONE:_____ WORK PHONE:_____ EXT: _____

CELL PHONE:_____ EMAIL:_____

## EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME:_____ CONTACT LAST NAME:_____

CONTACT HOME PHONE: _____ CONTACT CELL PHONE: _____

RELATIONSHIP TO PATIENT:_____ CONTACT ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

## FAMILY MEMBERS IN THE PRACTICE

NAME:_____ RELATIONSHIP TO PATIENT:_____

NAME:_____ RELATIONSHIP TO PATIENT:_____

NAME:_____ RELATIONSHIP TO PATIENT:_____

NAME:_____ RELATIONSHIP TO PATIENT:_____

## PRIMARY CARE / OTHER PHYSICIAN

PHYSICIAN NAME:_____ PRACTICE NAME: _____

CITY:_____ STATE:_____ ZIP:_____

## PHARMCY INFORMATION

PHARMACY NAME:_____ PHARMACY PHONE: _____

PHARMACY LOCATION:_____

***By signing below, I attest that the information provided above is true and accurate:***

Signature of Insured / Guardian:_____ Date:_____

8371 Yankee Street, Dayton, OH 45458

enlightened Medical CARE

# PATIENT REGISTRATION

## Authorization to release or use information for treatment, payment, or health care operations:

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by the Asthma & Respiratory Center of South Dayton in order to carry out treatment, payment, or health care operations. You should review the Practice s Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

## I agree and consent to releasing information to me in the following manners:

VIA MAIL — PLEASE INITIAL

- ❑ OK TO MAIL TO HOME ADDRESS _____
- ❑ OK TO MAIL TO WORK ADDRESS _____

VIA HOME TELEPHONE

- ❑ OK TO LEAVE DETAILED MESSAGE _____
- ❑ LEAVE CALL BACK NUMBER ONLY _____

VIA WORK TELEPHONE

- ❑ OK TO LEAVE DETAILED MESSAGE _____
- ❑ LEAVE CALL BACK NUMBER ONLY _____

VIA FAX

- ❑ OK TO FAX TO:_____ _____

**If we contact you and you are NOT available, may we leave information such as appointment confirmation, negative test results, surgery information and/or billing matters with another person?**

❑ YES ❑ NO

If yes, please list authorized person(s) name(s) here:

_____ _____ _____

**By signing below, I attest that the information provided above is true and accurate**

Signature of Insured / Guardian: _____ Date:_____

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# NOTICE OF ATTENDANCE EMC POLICIES

## ATTENDANCE POLICY

Our staff will provide you with appointment cards, which will indicate the day, date, and time for each appointment.

We will attempt to notify you of your scheduled appointment by phone but this is a courtesy call and is not required by our office.

We will do our best to schedule your appointments for the days and times that are most convenient for you.

Please understand that we do not accept walk-in patients. All of our appointments are scheduled.

This policy is to ensure that we can schedule new patients in a timely manner, along with offering our current patients convenient and timely appointments.

## CANCELLATIONS

We understand that occasionally difficulties arise which may prevent you from keeping a scheduled appointment.

You will be charged a fee of $50.00 for each appointment not cancelled within 24 hours of your scheduled appointment. This fee is not billable to your insurance company and is your responsibility.

If you miss more than (3) three appointments, you will be dismissed from the practice.

## LATE ARRIVALS

We will make every effort to see you at your scheduled time. In case of an emergency at the hospital or office we will offer you the option to wait to see the physician or to reschedule your appointment.

If you are more than (15) fifteen minutes late for your appointment you may be asked to reschedule.

## ANNUAL FEE

I understand that Enlightened Medical Care charges as annual fee of $250.00 for certain insurance carriers. This payments runs fiscally from June to June. A minimum of $50 payments may be made at a time.

## INSURANCE BALANCE INFORMATION

I understand that I will not have invoices mailed to my home. All invoices from EMC will be emailed and text only.

## I acknowledge being informed about Enlightened Medical Care Policies

Print Patient Name_____

Patient Signature_____Date_____

enlightened Medical CARE

# PATIENT QUESTIONNAIRE

LAST NAME:_____FIRST NAME: _____D.O.B.:_____

**Do you have any allergies to food or medications? If yes, please list below.**

_____

**Do you have any pets? If yes, what kind and how many?**

_____

**Are you a current smoker, if so, how long?** _____

**Do you have history of any of the following, please answer yes or no:**

**Diabetes** _____ **Cancer** _____

**High Blood Pressure** _____ **Sleep Apnea** _____

**Asthma** _____ **COPD** _____

**Emphysema** _____ **Bronchitis** _____

If you answered yes for any of the above, please specify:

_____

_____

**What is your occupation? If retired, what was your occupation?** _____

**Are you married?** ❑ YES ❑ NO

**Do you have children?** ❑ YES ❑ NO

**Have you had any of the following vaccinations? If yes when?**

| | | | | | | |
|---|---|---|---|---|---|---|
| Flu | ❑ YES | ❑ NO | When_____ | | | |
| Pneumonia | ❑ YES | ❑ NO | When_____ | | | |
| Shingles | ❑ YES | ❑ NO | When_____ | | | |
| Prevnar 13 | ❑ YES | ❑ NO | When_____ | | | |
| Covid | ❑ YES | ❑ NO | Type_____ | Date_____ | | |
| Covid Booster(s) | ❑ YES | ❑ NO | Type_____ | Date_____ | | |
| Covid Booster(s) | ❑ YES | ❑ NO | Type_____ | Date_____ | | |
| Covid Booster(s) | ❑ YES | ❑ NO | Type_____ | Date_____ | | |

**Have you had any recent visits to ER, hospital stays, chest X-rays?**
**If yes, please provide name of hospital and dates.**

_____

**List of current medications:**

Name of medications_____Dosages_____How often_____

Name of medications_____Dosages_____How often_____

Name of medications_____Dosages_____How often_____