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:______________________

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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:________________

8371 Yankee Street, Dayton, OH 45458

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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______________________________

ADOLESCENT 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 history of any of the following, please answer yes or no:

Constipation	Yes	No	Explain ____________________
Fever	Yes	No	Explain ____________________
Rash	Yes	No	Explain ____________________
Depression	Yes	No	Explain ____________________
Anxiety	Yes	No	Explain ____________________
Depression	Yes	No	Explain____________________
Cough	Yes	No	Explain ____________________
Diarrhea	Yes	No	Explain ____________________

Have you had any of the foillowing vaccines? if yes, when?

Flu	Yes	No	Date__________________	
MMR	Yes	No	Date __________________	
TDaP	Yes	No	Date__________________	
HepB	Yes	No	Date __________________	
Hep A	Yes	No	Date __________________	
Vericella	Yes	No	Date __________________	
HPV	Yes	No	Date __________________	
Pneumonococcal	Yes	No	Date __________________	
MenB	Yes	No	Date __________________	
Polio	Yes	No	Date __________________	
Covid	Yes	No	Date __________________	Type ______________________
Covid Booster	Yes	No	Date __________________	Type ______________________
Covid Booster	Yes	No	Date __________________	Type ______________________
Covid Booster	Yes	No	Date __________________	Type ______________________

Have you had any recent visits to ER, hospital stays, chest? if yes please provide the date and name of the hospial

____

____

List of current medications:

Name of medications________________________________ Dosages__________________ How often_________________

Name of medications________________________________ Dosages__________________ How often_________________

Name of medications________________________________ Dosages__________________ How often_________________

Name of medications ________________________________ Dosages__________________ How often_________________