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Matthew G. Hodges, D.O.
Kyle L. Ott, M.D.
Molly A. Tatum, D.O.

In Memory
Marcos E. Amongero, M.D.
September 4, 1960 - August 19, 2013

PATIENT INFORMATION

First Name: __________________________ Middle Name: ________________________ Last Name: __________________________

Date of Birth: __________ Patient ID: _______________ Marital Status: ______________ Gender: ____ SSN: ____________________

Address: ____________________________________ City: ________________________ State: ________ Zip Code: ___________

Home Phone: ________________________ Cell Phone: __________________________ Email: ______________________________

Employer: ____ Employer Phone Number: ____________________________________

Primary Care Physician: __________________________________ Referring Physician: ____

EMERGENCY CONTACT INFORMATION

First Name: __________________________ Last Name: ___________________________ Relationship: _________________________

Home Phone: _______________________ Cell Phone: ___________________________

GUARANTOR INFORMATION

First Name: __________________________ Last Name: ___________________________ Date of Birth: _________________________

Home Phone: _______________________ Cell Phone: ___________________________ Work Phone: __________________________

Address: ____________________________________ City: ________________________ State: ________ Zip Code: ____________

Relationship to Patient: ____________________________

INSURANCE INFORMATION

Primary Insurance: ____________________________________ Secondary Insurance: ____

Policy Holder Name: ___________________________________ Policy Holder Name: ____

Policy ID #: ____ Policy ID #: ____

Copay: ____ Copay: ____

WORKER'S COMP (if applicable)

Date of Injury: ____________________________________ Claim/ID #: ____

NOTICE OF PAYMENT POLICY AND PATIENT FINANCIAL AGREEMENT

I have read the Payment Policy and Patient Financial Agreement, and as the patient, his/her parent/guardian or duly authorized representative, understand and accept these terms.

Signed: _____________________________________ Witness: ____________________________________ Date: _________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Orthopaedic Institute of Dayton, Inc.'s Notice of Privacy Practices and understand that my protected health information may be used by the Orthopaedic Institute of Dayton, Inc. as described in the notice.

Patient's Name (Please Print): ____

Patient's Signature: ____ Date: _________________

Responsible Person (If Patient is a Minor) (Please Print): ____

Responsible Person's Signature: ____ Date: ___________________