Dayton Dandes MEDICAL CENTER
Prioritizing your health!

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DAYTON DANDES MEDICAL CENTER

Prioritizing your health

Patient Full Name: _____ Today's Date_____ Age _____

Date of Birth: _____ SS# _____ Marital Status: ○ Single ○ Married ○ Separated

E-mail Address: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Home Address: _____ City: _____ State and Zip: _____

Whom May We Thank for Referring You? _____

Do you have any allergies? ○ Yes ◉ No

If yes, please list_____

Employer Name: _____ Occupation: _____

Person to Contact in Case of Emergency: _____ Phone: _____

Name and Phone Number of Pharmacy You Use: _____

Responsible Party Information

Person Financially Responsible:	Relationship to Patient:
Home Address:	Home Phone:
Employer:	Business Phone:

Primary Insurance Information

Name of Insured:	Social Security No.:	Relationship to Patient:	Date of Birth:
	Address:		How Much is Your Deductible?
Member ID:		Group#:	

Secondary Insurance Information

Name of Insured:	Social Security #	Relationship to patient	Date of birth
	Address	Relationship to patient	Date of Birth
Member ID:			

Full Name: _____ Signature: _____

PATIENT FULL NAME: _____ DATE: _____

Please check the boxes that <u>apply to you or your immediate family members</u>

	YOU	RELATIVE	RELATIONSHIP TO YOU
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
Heart Problems	☐	☐	
Respiratory/Asthma	☐	☐	
Thyroid	☐	☐	
Arthritis	☐	☐	
Alcoholism	☐	☐	
Bleeding Disorders	☐	☐	
Epilepsy	☐	☐	
Heart Disease	☐	☐	
Intestinal/Colon	☐	☐	
Kidney Disease	☐	☐	
Low Blood Sugar	☐	☐	
Mental/Emotional Disorders	☐	☐	
Migraines	☐	☐	
Stroke	☐	☐	
Ulcers	☐	☐	
Cancer	☐	☐	
Lung Disease	☐	☐	
Seizures	☐	☐	
Urinary Problems	☐	☐	
Stomach Disorders	☐	☐	
Rheumatic Fever	☐	☐	
Liver Disease	☐	☐	
OTHER	☐	☐	

Personal Tobacco Use: Yes☐ No☐

If Yes: Current:☐ Past:☐ (Approx Quit Date:_____) Packs per day:___ Duration:___ years

PLEASE LIST ANY OTHER CONDITION YOU WOULD LIKE US TO BE AWARE OF

PATIENT FULL NAME: _____ DATE: _____

IF ANY OF THE FOLLOWING APPLY TO YOU, CHECK THE APPROPRIATE BOX(BOXES).

FEVER	☐	HEART MURMUR	☐
GAINED OR LOST WEIGHT RECENTLY	☐	PALPITATIONS	☐
LOSS OF APPETITE	☐	CHEST PAIN OR TIGHTNESS	☐
EASILY FATIGUED (tired easily)	☐	FAINTING OR FEELING FAINT	☐
COUGHING UP BLOOD	☐	SHORTNESS OF BREATH WITH LITTLE PHYSICAL EFFORT	☐
TENDENCY TO BE TOO HOT OR TOO COLD	☐	FREQUENT OR SEVERE HEADACHES	☐
WEAR CORRECTIVE LENSES	☐	BACK/NECK PAIN OR STIFFNESS	☐
BLURRING OF VISION	☐	NECK LUMP OR SWELLING	☐
HALOS APPEAR AROUND LIGHTS	☐	SWELLING IN THE GROINS OR ARMPITS	☐
EYE PAIN, REDNESS AND WATERING	☐	FEET DISCOMFORT OR DIFFICULTY WITH FEET	☐
DOUBLE VISION	☐	NUMBNESS OR WEAKNESS OF ANY PARTS OF THE BODY	☐
DIFFICULTY HEARING	☐	ACHING OR SWOLLEN JOINTS	☐
EARACHES	☐	LEG CRAMPS	☐
BUZZING OR NOISES IN EARS	☐	CONGESTED NOSE OR SNEEZING	☐
VERTIGO/DISEQUILIBRIUM	☐	HOARSENESS OF VOICE	☐
COLD HANDS AND/OR FEET	☐	TREMBLING OR SHAKING	☐
EXCESSIVE SWEATING	☐	CONVULSIONS	☐
FREQUENT NAUSEA OR VOMITING	☐	NOSE BLEEDS	☐
HEARTBURN	☐	BRUISE EASILY	☐
STOMACH OR ABDOMINAL DISCOMFORT	☐	SKIN PROBLEMS	☐
PAIN ON MOVING YOUR BOWELS	☐	GROWTHS ON SKIN	☐
IRREGULAR BOWEL MOVEMENT	☐	LUMPS IN BREAST	☐
EXCESSIVE THIRST	☐	ABNORMAL MENSES	☐
URINATING OVER SIX TIMES DAILY	☐	HOT FLASHES	☐
GETTING UP AT NIGHT TO URINATE	☐	ANXIETY/NERVOUSNESS	☐
WEAK OR SLOW URINE STREAM	☐	DEPRESSION	☐
CONSTANT FEELING OF HAVING TO URINATE	☐	IRRITABILITY	☐
BURNING WHEN URINATING	☐	HAVE YOU EVER BEEN OR ARE YOU CURRENTLY UNDER A CARE OF A PSYCHOLOGIST OR PSYCHIATRIST?	☐
Any other symptoms/concerns:			

SIGNATURE: _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. MARTIN DAYTON, DO, DAYTON-DANDES MEDICAL CENTER OF BENEFITS DUE TO ME FROM MY INSURANCE COMPANY OTHERWISE PAYABLE TO ME.

I FURTHER AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL INFORMATION REQUIRED BY MY INSURANCE CARRIER(S), SCOIAL SECURITY ADMINISTRATION AND HEALTHCARE FINANCING ADMINISTRATION OR ITS INTERMIDATES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM A COPY OF THIS AUTHORIZATION MAY BE USED IN LIEU OF THE ORIGINAL .

I ACKNOLEDGE FULL FINANCIAL RESPONSIBILITY FOR ALL SERVICES RENDERED AND AUTHORIZE TRANSFER OF ALL UNPAID AMOUNT TO MY VISA/MASTERCARD/AMEX AFTER 120 DAYS OF DATE OF SERVICE. I AGREE TO PAY ALL REASONABLE ATTORNEY FEES, FINANCIAL CHARGES AND COLLECTION COSTS IN THE EVENT OF DEFAULT OF PAYMENT OF MY CHARGES.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY, RELEASE OF MEDICAL INFORMATION, AND INSURANCE AUTHORIZATION.

FULL NAME: _____

SIGNATURE: _____

DATE: _____

PLEASE PROVIDE I.D.