Patient Registration

Account #
Chart #

PATIENT INFORMATION			
Last Name:		First Name:	MI:
SSN:		Date of Birth: _____/_____/_____	
Sex: ☐ M ☐ F		Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them	
Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never Married			
Address:		Apt/Unit:	
City:		State:	Zip:
Mobile Phone:	Home Phone:	Work Phone:	
Email:	Pharmacy:	Pharmacy Phone:	
Primary Care Provider:		Primary Care Provider Phone:	
Primary Care Provider Address:			

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
Is the patient covered by insurance? ☐ Y ☐ N	Does patient have secondary insurance? ☐ Y ☐ N
Insurance Co:	Insurance Co:
ID #:	ID #:
Group #:	Group #:
Name of Insured: ☐ Same as patient	Name of Insured: ☐ Same as patient
**If not same as patient fill out below:*	**If not same as patient fill out below:*
Insured SSN:	Insured SSN:
Relation to Patient:	Relation to Patient:
Date of Birth: _____/_____/_____	Date of Birth: _____/_____/_____
Employer:	Employer:

WORK OR ACCIDENT RELATED INJURIES			
Are you here for Work-Related Injury?: ☐ Y ☐ N	If yes, BWC: ☐ Y ☐ N	Claim #:	
Active: ☐ Y ☐ N	Date of Work-related Injury:		
Are you here for an auto-accident related injury?: ☐ Y ☐ N			
Are you here for non-auto accident related injury?: ☐ Y ☐ N	Type:	Date of Accident:	
Attorney Name:	Phone number:		

EMERGENCY CONTACT	
Contact Name:	Contact Name:
Phone:	Phone:
Alternate Phone:	Alternate Phone:
Relation to Patient:	Relation to Patient:

Please bring the following to your first appointment:

- ☐ Photo identification
- ☐ Health insurance card(s)
- ☐ Medications or a list of the medications you are currently taking
- ☐ A list of known allergies
- ☐ Patient Registration forms (if you've filled them out in advance)

Patient Registration

AUTHORIZATION AND RELEASE

By signing this consent form I acknowledge that I have read, understand, voluntarily consent to and authorize the following:

Authorization of Treatment:

I authorize examination, diagnosis and general treatment (including, but not limited to, the use of x-rays, diagnostic tests and non-invasive/minimally invasive procedures to be performed by physicians and staff at Dayton Outpatient Center (DOC). I realize that if surgery is required, I will be given additional information.

Guarantee of Payment:

INSURED: Assignment of Benefits: I authorize payment directly to Dayton Outpatient Center and its entities for all benefits otherwise payable to me. I understand that I am financially responsible for all charges not covered by insurance. I authorize Dayton Outpatient Center and its entities to submit claims to my insurance carrier(s), as well as medical records required to evaluate these claims for payment.

SELF-PAY/UNINSURED: Current self-pay rates apply and are due prior to or at the time of service, before leaving our facility.

Communications:

I consent to receive healthcare alerts from DOC and its entities via text, email, and patient portal.

Receipt of Privacy Practices:

By signing this consent form, I acknowledge that a copy of the Notice of Privacy Practices has been offered to me. I understand that the notice covers all entities of Dayton Outpatient Center including DOC Pain Management, DOC Vein Management, DOC Imaging Services, DOC Physical Therapy, Miami Vally Ambulatory Surgery Center, Access Surgery Center of Ohio, Dayton Anesthesia Associates, AccessMD Urgent Care and Meta Medical Research Institute. Meta Medical Research Institute may use data for screening purposes if you chose to participate in a clinical trial. I understand that DOC reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager.

Release of Medical Records:

I authorize Dayton Outpatient Center and its Affiliates to release verbally, electronically and/or in writing confidential medical information obtained during the course of my examination and/or treatment to any person or entity including my insurance carrier, employer (if treatment is related to employment), and/or other healthcare provider(s) for purposes of treatment, payment of charges, quality assurance and utilization review. I understand that should I choose not to release my medical records to a specific entity and/or person(s) I must specifically state so in writing for inclusion in my medical record.

Patient Signature: _____ Date: _____

Responsible Party: _____ Date: _____

No-Show and Cancellation Policy

1. If cancellation is necessary, we require that you contact our office at least 24-hours in advance for office visits and procedures to avoid a potential cancellation fee

2. A "no-show" or missed appointment without 24-hour notification may be charged a fee of $50 for Office Visits or $100 for Procedures and Diagnostic Testing (incl. Ultrasounds). These fees are not billable to your insurance company and will be patient's responsibility.

3. Repeated missed appointment may result in the termination of the physician/patient relationship

4. If you are 15 or more minutes late for your appointment, the appointment may be canceled and rescheduled

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Patient Responsibility

Below fees are not billable to your insurance company and will be patient's responsibility.

Deductibles:
Is the amount you have to pay for healthcare services before your insurance plan starts to pay. You are responsible for the full amount of office visits, diagnostic testing, and procedures until the deductible amount is met each year.

Co-Pays:
Based on your agreement with your insurance plan, a copay is required to be paid at time of service before your insurance will pay. After we file a claim to your insurance plan(s) after your visit and any procedures performed, if there is any remaining amount left after your insurance pays, we will send you a statement for the balance.

Co-Insurance:
A percentage you pay for covered health care services (for example 20% of the allowed amount). Your insurance plans will determine the amount they will allow as payment for a certain item or service, where a set percentage of that "allowed amount" will be the patient's responsibility.

Patient Account Balances:
If you accumulate a balance on your account, DOC requires that you settle your balance within 30 days before your balance transfers to a debt collection agency. If you are unable to do so, DOC policy requires you to create a clear payment plan with our Patients Account team before seeing the doctor.

Your signature below indicates that you have read this policy, understand it and agree to comply with its requirements.

Patient Name: _____

Patient/Legally Responsible Person Signature: _____ Date: _____

Medical History

PATIENT INFORMATION	
Height:	Weight:
Tobacco Use: ☐ Y ☐ N How much? _____ PPD; _____ Yrs.	
Alcohol Use: ☐ Y ☐ N How much?	

Please list your past surgeries with dates or provide list:

Past Surgery 1:	Surgery Date:
Past Surgery 2:	Surgery Date:
Past Surgery 3:	Surgery Date:
Past Surgery 4:	Surgery Date:
Past Surgery 5:	Surgery Date:
Past Surgery 6:	Surgery Date:
Past Surgery 7:	Surgery Date:

Please list your current Medications or provide list:

Medication 1:
Medication 2:
Medication 3:
Medication 4:
Medication 5:
Medication 6:
Medication 7:

Please list your current Allergies or provide list:

Allergy 1:
Allergy 2:
Allergy 3:
Allergy 4:
Allergy 5:
Allergy 6:
Allergy 7:

Have you ever been diagnosed with any of these? (check any that apply)

☐ Angina	☐ Coronary Heart Disease	☐ Kidney Stones
☐ Arthritis	☐ Diabetes	☐ Liver Disease
☐ Blood Disorders	☐ Heart Attack	☐ Seizures
☐ Cancer	☐ Hepatitis	☐ Stroke
☐ CHF	☐ High blood Pressure	☐ Thyroid Disease
☐ COPD/Emphysema	☐ Intestinal Issues	☐ Ulcers/Gastritis

Have you ever had any of the following happen to you? (check any that apply)

☐ Head (history of trauma)	☐ Passing Out	☐ Diarrhea/Constipation
☐ Bloody Stool	☐ Bloody Urine	☐ Shortness of Breath
☐ Skin Rash	☐ Upset Stomach/Nausea	☐ Weakness/Loss of Strength
☐ Painful Joints	☐ Swelling	☐ Dizziness
☐ Allergies	☐ Depression/Anxiety	☐ Eyesight Changes
☐ Chest Pain	☐ Hearing Loss	☐ Alcohol/Substance Abuse

Vein History Form

GENERAL INFORMATION	
Today's Date:	Clinic Location:
Patient Name:	Date of Birth: _____/_____/_____

SYMPTOMS					
Aching/Pain in legs:	☐ Y ☐ N	Throbbing:	☐ Y ☐ N	Hepatitis:	☐ Y ☐ N
Heaviness:	☐ Y ☐ N	Swelling:	☐ Y ☐ N	High Blood Pressure:	☐ Y ☐ N
Tiredness/Fatigue:	☐ Y ☐ N	Asthma/COPD:	☐ Y ☐ N	Diabetes:	☐ Y ☐ N
Itching/Burning/Warmth:	☐ Y ☐ N	Heart Disease:	☐ Y ☐ N	Cancer:	☐ Y ☐ N
Leg Cramps:	☐ Y ☐ N	Peripheral Arterial Disease:	☐ Y ☐ N	Leg Trauma/Surgery:	☐ Y ☐ N
Restlessness Leg:	☐ Y ☐ N	HIV:	☐ Y ☐ N		

Do your symptoms interfere with your sleep?: ☐ Y ☐ N			
Are your symptoms worse later in the day?: ☐ Y ☐ N			
Are your symptoms worse with or after activity?: ☐ Y ☐ N			
Do your symptoms keep you from doing anything?: ☐ Y ☐ N			
Does prolonged sitting or standing aggravate your legs?: ☐ Y ☐ N			
How long have you had problems with your veins?: _____ ☐ Months or ☐ Years			
Do your legs effect your daily living?: ☐ Y ☐ N	If yes how?:		
Pain Level: _____ /10	Constant: ☐ Y ☐ N	Pain Worse: ☐ AM ☐ PM ☐ None	
Does anything help your pain?: ☐ Y ☐ N	What Helps?:		

Do you have any Peripheral Arterial Disease (PAD) Symptoms?
Was diagnosed with PAD in past: ☐ Y ☐ N
Have/had cramping leg pain that worsens with walking, forcing me to stop walking: ☐ Y ☐ N
Feet/Toes become pale and painful with exercise or when elevating them: ☐ Y ☐ N
Have/had ulcers on feet or toes: ☐ Y ☐ N

Conservative Measures used currently or previously					
Pain Medication:	☐ Y ☐ N	Weight Loss:	☐ Y ☐ N	Leg Elevation:	☐ Y ☐ N
Job Change:	☐ Y ☐ N	Exercise:	☐ Y ☐ N		
Prescribed Compression stockings/hose or leg wraps?: ☐ Y ☐ N					
Please list your weight: _____ lbs and height: _____ ft _____ in					

Have you ever had any vein treatments? (check any that apply)		
☐ Pain Medications	☐ Exercise	☐ Weight Loss
☐ Compression Stockings	☐ Sclerotherapy	☐ Endovenous Ablation
☐ Venaseal	☐ Stab Phlebectomy	☐ Physical therapy
☐ Varithena Therapy	☐ Laser Therapy	☐ Leg Elevation

OFFICE USE ONLY

Blood Pressure: _____ / _____ R L Patient ID#: _____

Staff Signature: _____ Date: _____

Provider Signature: _____ Date: _____