5900 N Main St #3 Dayton, OH 45415
www.shilohfamilymedicine.org
937-277-9371

PLEASE
1. COMPLETE FORM
2. PRESENT PICTURE ID
3. PRESENT INSURANCE CARD

NEW PATIENT DEMOGRAPHIC SHEET

PATIENT INFORMATION:			☐ PREVIOUSLY DR CLACK'S PATIENT
LAST NAME	FIRST	MIDDLE	MAIDEN
ADDRESS	CITY	STATE	ZIP
DOB	SSN	EMAIL	PREFERRED PHONE ☐ OK TO LEAVE MESSAGE
MARITAL STATUS	RELIGION	EMPLOYER	
GUARANTORS:			
CARD HOLDER NAME	DOB		
PHONE	CARD HOLDER SSN		
EMERGENCY CONTACT INFORMATION:			
NAME	PHONE NUMBER		
RELATIONSHIP	MAY THE OFFICE DISCUSS PERSONAL & MEDICAL INFORMATION? ☐ YES ☐ NO		
NAME	PHONE NUMBER		
RELATIONSHIP	MAY THE OFFICE DISCUSS PERSONAL & MEDICAL INFORMATION? ☐ YES ☐ NO		
LEGAL DOCUMENTS			
GUARDIANSHIP/CUSTODY NAME	PHONE NUMBER		
HEALTHCARE POWER OF ATTORNEY NAME	PHONE HUMBER		

AUTHORIZATION AND EXPIRATION:

HIPAA: Please read the below information:
I hereby consent to and authorize my physician to discuss records obtained in the course of my diagnosis and treatment to any insurer, compensation carrier, health care facility, or any entity which may be providing financial assistance for hospital, medical or extended care facility. I specifically authorize my physician to release records, which may or may not contain information concerning treatment relating to HIV testing, AIDS or related conditions, treatment of psychiatric conditions, and or treatment of alcoholism and or drug abuse to my insurance company. For value received and in consideration of services rendered by Shiloh Family Medicine to the above patient/guarantor. I/we hereby agree to promptly pay with settlement in full for service, deeming it as "not medically necessary" I agree to be financially responsible and any attorney or collection fees insurance due to delinquency in payment will also be charged to my account. By signing I state that I was given the opportunity to read and fully understand my rights, privacy, and responsibilities as a patient in the notice of privacy is consent is subject to revocation by the patient/guarantor, if done so in writing or with revocation will expire one year from this date.

SIGNATURE:	
SIGNATURE OF PATIENT	DATE
SIGNATURE OF INDIVIDUAL AUTHORIZED BY PARENT	DATE
RELATIONSHIP TO PATIENT	