



5900 N Main St #3 Dayton, OH 45415
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 937-277-9371

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

NEW PATIENT DEMOGRAPHIC SHEET

PATIENT INFORMATION:					<input type="checkbox"/> PREVIOUSLY DR CLACK'S PATIENT	
LAST NAME		FIRST		MIDDLE	MAIDEN	
ADDRESS			CITY		STATE	ZIP
DOB	SSN	EMAIL		PREFERRED PHONE	<input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME			PHONE NUMBER			
RELATIONSHIP			MAY THE OFFICE DISCUSS PERSONAL & MEDICAL INFORMATION? <input type="checkbox"/> YES <input type="checkbox"/> NO			
LEGAL DOCUMENTS						
GUARDIANSHIP/CUSTODY NAME			PHONE NUMBER			
HEALTHCARE POWER OF ATTORNEY NAME			PHONE NUMBER			
AUTHORIZATION AND EXPIRATION:						
<p>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.</p>						
SIGNATURE:						
SIGNATURE OF PATIENT				DATE		
SIGNATURE OF INDIVIDUAL AUTHORIZED BY PARENT				DATE		
RELATIONSHIP TO PATIENT						