Patient Registration Form

Please **PRINT** Clearly (Use **ONLY** black or blue Ink)

PATIENT

LAST NAME	FIRST NAME	MI	❑ MALE ❑ FEMALE

EMAIL ADDRESS:	OCCUPATION	PRIMARY DUTIES

STREET ADDRESS	APARTMENT # OR P.O. BOX	PHONE #

CITY	STATE	ZIPCODE	CELLPHONE#

SOCIAL SECURITY NUMBER	DATE OF BIRTH	HEIGHT	AGE	❑Married ❑Single ❑Widowed ❑Divorced

ETHNICITY (PLEASE CHECK ONE) ○ African Amer ○ Asian ○ Caucasian ○ Hispanic ○ Native Amer ○ Pacific Islander/Hawaiian ○ Other

YOUR EMPLOYER	❑Full-time ❑ Part-time ❑Self-employed ❑Homemaker ❑Retired ❑ Disabled ❑ Unemployed ❑Student

EMERGENCY CONTACT NAME:	Relationship to patient	EMERGENCY CONTACT NUMBER:

REFERRING PHYSICIAN NAME:	*REFERRING* PHYSICIAN #:	PRIMARY CARE PHYSICIAN **(PCP)** NAME:	PRIMARY CARE PHYSICIAN #:

RESPONSIBLE

PERSON RESPONSIBLE FOR PAYMENT ❑ CHECK HERE IF SAME AS ABOVE INFORMATION
❑CHECK HERE ***AND*** FILL OUT BELOW INFORMATION IF PATIENT IS UNDER 18

LAST NAME	FIRST NAME	MI	❑ MALE ❑ FEMALE

STREET ADDRESS	APARTMENT # OR P.O. BOX

ZIP CODE	STATE	ZIP CODE

SOCIAL SECURITY NUMBER	DATE OF BIRTH	❑MARRIED ❑SINGLE ❑DIVORCED ❑WIDOWED

RESP PARTY EMPLOYER:	RESP PARTY OCCUPATION:	EMPLOYER PHONE NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY

INSURANCE COMPANY NAME:	EFFECTIVE DATE:	IDENTIFICATION/SUBSCIBER#

SUBSCRIBER NAME(PERSON THAT HOLDS INSURANCE): ❑*CHECK HERE IF SAME AS PATIENT NAME*	GROUP NUMBER:

SUBSCRIBER SOCIAL SECURITY NUMBER:	**SUBSCRIBER** DATE OF BIRTH:	**SUBSCRIBER** EMPLOYER:

INSURANCE CLAIMS MAILING ADDRESS:	INSURANCE PHONE NUMBER:

SECONDARY INSURANCE COMPANY COVERAGE

INSURANCE COMPANY NAME:	EFFECTIVE DATE:	**IDENTIFICATION /SUBSCRIBER#**

SUBSCIBER NAME(PERSON THAT HOLDS INSURANCE): ❑CHECK HERE IF SAME AS PATIENT NAME	GROUP NUMBER:

SUBSCRIBER SOCIAL SECURITY NUMEBR:	**SUBSCRIBER** DATE OF BIRTH:	**SUBSCRIBER** EMPLOYER:

INSURANCE CLAIMS MAILING ADDRESS:	INSURANCE PHONE NUMBER:

RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage as shown above. I assign all insurance payments to be made directly to this office. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions,. I agree that should this account be referred to an outside agency or an attorney for collections, I will be responsible for all collection cost , attorney fees and court cost. I have read and understand all of the above and have agreed to these statements.

_____ _____

PATIENT SIGNATURE (FULL NAME) DATE

PATIENT REGISTRATION

Patient Registration Form Part 2

PATIENT NAME:		DATE OF BIRTH	AGE
CURRENT HEIGHT	CURRENT WEIGHT	DATE OF LAST PHYSICAL EXAMINATION:	

REASON FOR TODAYS VISIT:
❑**H&P** (CONSULT) FOR A WEIGHT LOSS SURGERY PROCEDURE (LAP BAND OR GASTRIC BYPASS)
❑ **CONSULT FOR A GENERAL SURGERY** (EX: GALLBLADDER, HERNIA, BREAST, COLON, APPENDIX, CYST)
❑ **OTHER** (PLEASE EXPLAIN)

Drug Allergies (list all)		

Medications & Dosages (attach list if necessary)		
Medication Name	Medication Dosage	What condition is medicine take for?
1		
2		
3		
4		
5		
6		

Surgical History		
Surgery	*Month/Year*	*Hospital Name*

Medical History

Please circle yes or no if you have been treated for any of the following

AIDS OR HIV	YES NO	**EPILEPSY**	YES NO	**LOW BLOOD PRESSURE**	YES NO	**SEIZURE DISORDER**	YES NO
ANEMIA	YES NO	**GLAUCOMA**	YES NO	**MEASLES**	YES NO	**SLEEP APNEA**	YES NO
ASTHMA	YES NO	**HEART DISEASE**	YES NO	**MIGRAINES**	YES NO	**SMALL POX**	YES NO
BACK TROUBLE	YES NO	**HEMORRHOIDS**	YES NO	**MITRAL VALVE PROLAPSE**	YES NO	**STROKE**	YES NO
BLADDER INFECTIONS	YES NO	**HEPATITIS**	YES NO	**MUMPS**	YES NO	**THYROID DISEASE**	YES NO
BRONCHITIS	YES NO	**HERNIA**	YES NO	**OSTEOARTHRITIS**	YES NO	**TRANSFUSIONS**	YES NO
CANCER	YES NO	**HIGH BLOOD PRESSURE**	YES NO	**PNEUMONIA**	YES NO	**TUBERCULOSIS**	YES NO
CHICKENPOX	YES NO	**HIVES OR ECZEMA**	YES NO	**POLIO**	YES NO	**ULCERS**	YES NO
DIABETES	YES NO	**INFECTION MONO**	YES NO	**RHEUMATIC FEVER**	YES NO	**VENEREAL DISEASE**	YES NO
DIPTHERIA	YES NO	**KIDNEY DISEASE**	YES NO	**RHEUMATOID ARTHRITIS**	YES NO	**OTHER:** _____	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____ Date:_____

PATIENT REGISTRATION

Patient Registration Form Part 3

Please **PRINT** Clearly

PATIENT NAME:	**DATE OF BIRTH:**

FAMILY HISTORY

ANY BLOOD RELATIVE THAT HAVE HAD THE FOLLOWING LISTED BELOW:

ALLERGIES	YES NO, **RELATIONSHIP**:	**EPILEPSY**	YES NO, **RELATIONSHIP**:
ANEMIA	YES NO, **RELATIONSHIP**:	**HEART DISEASE**	YES NO, **RELATIONSHIP**:
BLEEDING	YES NO, **RELATIONSHIP**:	**HIGH BLOOD PRESSURE**	YES NO, **RELATIONSHIP**:
CANCER	YES NO, **RELATIONSHIP**:	**STROKE**	YES NO, **RELATIONSHIP**:
DIABETES	YES NO, **RELATIONSHIP**:	**TUBERCULOSIS**	YES NO, **RELATIONSHIP**:

SOCIAL HISTORY

Do you smoke? (cigars, cigarettes, marijuana)	YES	NO	If yes, quantity per day?
Do you drink alcohol?	YES	NO	If yes, quantity per day?
Do you drink caffeine?	YES	NO	If yes, quantity per day?
Do you or have you in the past used illegal drugs?	YES	NO	If yes, quantity per day?

OTHER HISTORY

HAVE YOU HAD ANY OF THE FOLLOWING:

Psychological Evaluation	YES NO	**IF YES, When?**	**Physician Name**:_____		
EGD	YES NO	**IF YES, When?**	**Rubella Vaccine**	YES NO	**IF YES, When?**
Colonoscopy	YES NO	**IF YES, When?**	**Rectal Exam**	YES NO	**IF YES, When?**
Flu Vaccine	YES NO	**IF YES, When?**	**Stool in blood test**	YES NO	**IF YES, When?**
Tetanus Shot	YES NO	**IF YES, When?**	**Eye Exam**	YES NO	**IF YES, When?**
Hepatitis Vaccine	YES NO	**IF YES, When?**	**Cholesterol Test**	YES NO	**IF YES, When?**
Heart Cath	YES NO	**IF YES, When?**	**Prostate Exam (MEN ONLY)**	YES NO	**IF YES, When?**

WOMEN ONLY:

Age at onset of menstrual cycle?		**Date of last menstrual Cycle**?	
Do you use birth control?	Yes No	**If YES**, what type:	
Number of Pregnancies	**Number of Live Births**		
Number of Abortions	**Number of Miscarriages**		
Breast Exam	Yes No	**If YES**, when?	Doctor's Name
Mammogram	Yes No	**If YES**, when?	Doctor's Name
Pap smear	Yes No	**If YES**, when?	Doctor's Name

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____ Date:_____

PATIENT REGISTRATION

Dayton Bariatric & General Surgery Center

A Member of Kettering Physicians Network

Patient Financial Information

- All insurance company co-pays are due at the time of service. Following surgery, patients are not required to pay a co-pay or office visit charge for the 1st 90 days, or according to individual insurance mandates. Our office is considered a *specialist.* We will collect co-pays accordingly. Co-payments are due at the time of service. Our office accepts cash, check, credit card, money order or cashier check.
- All patients will be required to update their personal information 'in writing' on a yearly basis. This will verify that your personal information has not changed.
- If a new bariatric patient is not covered by insurance there will be a charge for the 1st visit. This charge will be due at the time of service. If not covered by insurance Lap Band adjustment charges will be due the same day as service.
- $35 fee will be assessed on your account for any returned checks. Our office now processes check payments electronically. If you do not have sufficient funds in your account, please have an alternate payment (credit card, cashier check or cash) available at the time of your visit.
- Patients are responsible to notify Dayton Bariatric & General Surgery Center (A Member of Kettering Physicians Network), of any personal information changes (i.e.: phone, insurance, address, marital status, etc). Failure to do so can cause delays in billing, scheduling or other problems. If the patient fails to provide information any unpaid balance will be the patient's responsibility.
- Patients that are unable to keep appointments must call to cancel appointments prior to their appointment. Any no shows for appointments, without notifying our office, beforehand, may be charged $20. Excessive cancellations risk being released from the practice of Dayton Bariatric & General Surgery Center (A Member of Kettering Physicians Network),
- The responsible party for a patient account is responsible for any balance due after insurance reimbursement(s) are made.
- If a payment is not received on an account within 90 days, then a ten-day notice will be sent on the patient's statement. If payment is not made within 10 days of receipt of that statement, your account may be forwarded to our collections agency and all inquiries thereafter will be referred to them.
- As the patient it is your responsibility to know your insurance company's policies. Be sure to contact your insurance carrier to verify that requested tests or services are a covered benefit. Many procedures or services are not covered by insurance carriers. It is understood that your doctor may order services or testing that may or may not be paid by your insurance carrier. If the insurance carrier does not cover the charges for any reason, it is the patient's responsibility to pay for the balance. Benefits and coverage rules and policies differ among insurers and even between different plans of the same insurer. Whether you have insurance coverage or not, any services rendered are the responsibility of the patient for payment. Unpaid charges that are not paid
- Cash pay surgery patients may make payment by credit card, money order or cashier check. (Cash will not be accepted for pre-payment on surgeries, personal check payments will be processed immediately for verification of availability of funds. If your check payment is denied payment will be required by credit card, money order or cashier check only. Pre-payment must be made prior to being scheduled for surgery. **There are no payment arrangements and no surgery dates given without full payment being received. Any charges incurred in excess of the original self-pay fee are the responsibility of the patient.**
- Monthly payment plans are NOT available for any of our surgeries.
- Copies of medical records can be made, as needed. There is a charge for copies of records in accord with guidelines set out in OH revised code 3701.741. Please allow time for your files to be located and to run the copies needed.
- Disability paperwork and miscellaneous paperwork that needs filled out by our office is done at a $5 charge per form This fee must be paid prior to the forms being filled out There is a 5 business day time period to fill out these forms. For forms needed in less than 5 business days, there is an additional $5 charge per form. Forms can be mailed, faxed or dropped off in our office. It is preferred that forms be dropped off at our Centerville office. For forms mailed or faxed, there is no guarantee that they will be received in our office.
- After surgery many bariatric patients are prescribed Lovenox®. This medicine may not be covered by your insurance. It is recommended that you contact your insurance to see if it will be covered. Otherwise, the payment for the meds will be collected by you the patient.
- Charges billed by the hospital are to be handled through the hospital billing department. Dayton Bariatric & General Surgery Center maintains accounts for office visits and surgeon fees incurred.

I have read the above and understand that I am financially responsible for all charges whether or not paid by insurance. I understand that charges listed above are subject to change. I hereby authorize the doctor to release all information necessary to secure the payment of benefits, I authorize the use of this signature on all insurance submissions.. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney fees and court costs. I have read and understand all of the above and have agreed to these statements. I understand that Dayton Bariatric & General Surgery Center (A Member of Kettering Physicians Network) may change the above requirements at any time.

Patient Signature:_____ Date:_____

PATIENT FINANCIAL INFORMATION

Dayton Bariatric & General Surgery Center

A Member of Alliance Physicians
7740 Washington Village Drive, Suite 110, Dayton OH 45459
165 Edwin C. Moses Blvd. Dayton OH 45407 (VJC Health Center)
Dayton OH 45459
937-439-4145 phone 937-439-4371 fax

HIPAA Compliancy

Providers and health insurers are required to comply with your right to:

- Ask to see and get a copy of your health records
- Have corrections added to your health information
- Receive a notice that tells you how your health information may be used and shared
- Decide if you want to give your permission for specific purposes, such as for marketing
- Get a report on when and why your health information was shared for certain purposes

What information is protected?

- Information your healthcare providers put in your medical record
- Conversations your doctor has about your care or treatment with nurses and others
- Information about you in your health insurer's computer system
- Billing information about you at your physicians office

Please list any person(s) that you agree that your information may be released to: ex. doctor, spouse, parent, etc.

NAME	***RELATIONSHIP TO PATIENT***	***ADDRESS***	***PHONE***

_____ **YES,** It is *okay to leave messages with detail* on my home voice mail in reference to my surgery or follow-up

_____ **NO**, do **not** leave messages with detail on my home voice mail just a general name and number

By signing below I agree that any names listed above may have access to my medical records at Dayton Bariatric & General Surgery Center. This includes, but is not exclusive to: calling to make appointments, requesting medical information, picking up any medical information in the office, etc. I understand that if I do not want the above contacts to have any further access to my medical information at Dayton Bariatric & General Surgery Center that it is my responsibility to keep this document up to date with any changes.

Patient Signature:_____ Date:_____

HIPAA Compliancy