

Dayton Family Practice, Assoc. Inc

3328 S Smithville Rd, Dayton Oh 45420
Phone- 937-254-5661 Fax- 937-254-7367
<https://daytonfpa.com>

Patient Name _____

Address _____

City _____ State _____ Zip Code _____ DOB ____/____/____

Sex ____ SSN# _____ Home Phone# _____

Work Phone # _____ Cell phone # _____

Marital Status _____ Race _____ Ethnic Group _____

Insurance Information

Primary Insurance _____ Policy # _____

Secondary Insurance _____ Policy # _____

Emergency Contact Information

Name _____ Relation _____ Phone # _____

Consent to Treat

I authorize DAYTON FAMILY PRACTICE to provide treatment and diagnostic services to me. All rendered services, including any changes or updates in existing treatment, will be discussed with me prior to implementation.

Signature of patient _____ Date _____

Release of Medical Information

I authorize my insurance benefits to be paid directly to DAYTON FAMILY PRACTICE.

I acknowledge that I am financially responsible for NON- COVERED services, or if my insurance plan is not accepted by DAYTON FAMILY PRACTICE.

Signature of patient _____ Date _____