Dayton Family Practice, Assoc. Inc

3328 S Smithville Rd, Dayton Oh 45420
Phone- 937-256-5661 Fax- 937-254-7367
http://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_____