Over 10 years of caring
Dayton Physicians Network
Cancer Care and Urology

Patient Profile

Today's Date: _____

PATIENT INFORMATION

Name: _____

Address: _____

City, State, Zip: _____

Primary Phone: _____
☐ Home ☐ Work ☐ Cell

Additional Phone: _____
☐ Home ☐ Work ☐ Cell

Primary Language: ☐ English ☐ Spanish ☐ Chinese
☐ Japanese ☐ Russian ☐ French ☐ German
☐ Other _____

SPECIAL COMMUNICATION NEEDS: ☐ Yes ☐ No
If Yes, explain: _____

PATIENT EMPLOYMENT:
☐ Employed ☐ Unemployed ☐ Student ☐ Retired
Employer: _____

Sex: ☐ Male ☐ Female **Date of Birth:** _____

Social Security #: _____

E-mail: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: (check one)
☐ Caucasian ☐ Black-African American ☐ Asian
☐ American Indian-Alaska Native ☐ Multi-Racial
☐ Native Hawaiian/Other Pacific Islander
☐ Other _____

Ethnicity:
☐ Hispanic ☐ Non-Hispanic ☐ Other _____

EMERGENCY CONTACT:
Name/Relationship: _____
Phone: _____

HOW DID YOU HEAR ABOUT US?
☐ Friends ☐ Family ☐ Physician ☐ Web ☐ Other
Referring/Other Physician _____
Primary Care Physician _____

PATIENT'S INSURANCE INFO: PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST

PRIMARY INSURANCE: ☐ *Other* _____

Insurance Company: _____
Insured Party: _____
Relationship to Patient: _____
Insured Sex: ☐ Male ☐ Female
Effective Date of Insurance: _____

Insured ID: _____
Policy Group #: _____
Group Name: _____
Insured SS #: _____
Insured Date of Birth: _____

SECONDARY INSURANCE: ☐ *Same as Patient* ☐ *Same as Guarantor* ☐ *Other*

Insurance Company: _____
Insured Party: _____
Relationship to Patient: _____
Insured Sex: ☐ Male ☐ Female
Effective Date of Insurance: _____

Insured ID: _____
Policy Group #: _____
Group Name: _____
Insured SS #: _____
Insured Date of Birth: _____

RESPONSIBLE PARTY: ☐ *Same as Patient (see above)* ☐ *Same as Insured (see above)* ☐ *Other (list below)*

Name: _____
Address: _____
_____
City, State, Zip: _____

Guarantor's Date of Birth: _____
Guarantor's SS #: _____
Relationship to Patient: _____

I authorize Dayton Physicians Network to release to the insurance carrier or any other person responsible for payment any information including medical information needed to process my claims. I permit a copy of the authorization to be used in the place of the original. I certify the information I have given to be true and correct. I authorize payment directly to the physician or Dayton Physicians Network. I understand that services not covered by my insurance are the responsibility of the patient.

SIGNATURE OF PATIENT _____ **DATE** _____