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*In Memory*  
 Marcos E. Amongero, M.D.  
 September 4, 1960 - August 19, 2013

**PATIENT INFORMATION**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Patient ID: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Gender: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Employer Phone Number: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**GUARANTOR INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_  
 Policy Holder Name: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_  
 Policy ID #: \_\_\_\_\_ Policy ID #: \_\_\_\_\_  
 Copay: \_\_\_\_\_ Copay: \_\_\_\_\_

**WORKER'S COMP (if applicable)**

Date of Injury: \_\_\_\_\_ Claim/ID #: \_\_\_\_\_

**NOTICE OF PAYMENT POLICY AND PATIENT FINANCIAL AGREEMENT**

I have read the Payment Policy and Patient Financial Agreement, and as the patient, his/her parent/guardian or duly authorized representative, understand and accept these terms.

Signed: \_\_\_\_\_ Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I have received the Orthopaedic Institute of Dayton, Inc.'s Notice of Privacy Practices and understand that my protected health information may be used by the Orthopaedic Institute of Dayton, Inc. as described in the notice.

Patient's Name (Please Print): \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Responsible Person (If Patient is a Minor) (Please Print): \_\_\_\_\_

Responsible Person's Signature: \_\_\_\_\_ Date: \_\_\_\_\_