Dayton Lung & Sleep Medicine

8881 North Main St.

Dayton, Ohio 45415

(937) 832-5292

Dear Patient ______________________________________

Please fill out ALL enclosed form(s) (even if you think they do not pertain to your situations) and bring them with you to your appointment with:

Dr. Mustafa Quadri, Dr. Martin Ambrose, Dr. Fahim Khan, Dr. Souheil Darwich

Also, please bring your insurance card(s), picture ID, and a list of all your current medications.

If you have any questions or need to reschedule your appointment, please call us at the number listed above.

Appointment Date & Time: ______________________________________

Locations:

___ Main Office
8881 North Main St.
Dayton, Ohio 45415

___ Beavercreek office
1244 Meadowbridge Dr.
Beavercreek, Ohio 45434
Located inside of Beavercreek Family Physicians

___ Greenville Office
742 Sweitzer St. Ste B
Greenville, Ohio 45358
Located across from Wayne Healthcare-Main Entrance, inside the Premier Building

___ Wilmington Office
610 West Main Street
Wilmington, Ohio 45177
Located in the hospital, at the sleep lab, on the second floor Enter through the main entrance in the back of the hospital, take the gold elevators to the second floor, turn left and follow it to the end of the hall.

Patient Registration
Please print clearly and complete the following form

PATIENT INFORMATION

Name________________________ Home Phone#( )__________ Cell Phone#( ) __________

Address________________________ City__________ State_____ Zip__________

Social Security # ___-___-_____ Date of Birth__________ Sex M F Marital Status (S) (M) (W)

Race __________ Religion __________

Employer ________________________ Full Time/Part Time/Retired

Employer Phone # ( )__________

Emergency Contact________________ Relationship __________ Phone# ( )__________

Family Physician ________________ Phone# ( )__________ Referring Physician __________

INSURANCE INFORMATION

Primary Insurance________________ Subscriber Name__________ DOB________

Policy ID ________________ Group Name__________ Group#__________

Secondary Insurance________________ Subscriber Name__________ DOB________

Policy ID ________________ Group Name __________ Group#__________

I authorize DAYTON LUNG AND SLEEP MEDICINE, INC, to release any information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THIS CLAIM.
I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is valid as the original.

Signature________________________ Date__________

MEDICARE PATIENTS (PLEASE READ AND SIGN IF YOU ARE COVERED BY MEDICARE)

I certify that the information given by me in applying for payment under Title VIII of the Social Security Act is current. I authorize any holder of medical or other information about me to release to the Health Information needed for this or a related Medicare claim.
I request that benefits payable for covered Medicare services be paid to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.
I request that payment under the Medical Insurance Program be made either to me or Mustafa Quadri, M.D., Martin P.Ambrose, M.D., Fahim Z. Khan, M.D, Souheil M. Darwich, M.D on any services furnished by above listed physicians.

Signature________________________ Date__________