Patient Information and Consent

What is the reason for your visit today?	

Patient information

Last Name	First Name	Date of Birth	Social Security #	Birth Sex ☐ Male ☐ Female
Permanent Mailing Address		City, State ZIP		
Email Address		Primary Phone		Phone Type ☐ Home ☐ Cell
Preferred Language		Race ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ American Indian/Alaska Native ☐ Prefer not to answer		
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino				
Emergency Contact Name		Relationship to Patient	Emergency Contact Phone	

Guarantor/Responsible Party (person responsible for payment)

Legal Name of Responsible Party (First, Middle, Last)	Social Security #
Email Address (if different from the patient email above)	Date of Birth

Authorization for Release of Information

May we leave testing results or referral information in email? ☐ Yes ☐ No

May we leave testing results or referral information in voicemail? ☐ Yes ☐ No

Name of person who may receive information on your behalf regarding testing or referrals

Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment, diagnostic procedures and obtaining all of my medication/ prescription history when using an electronic system provided by Doctors Care and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Doctors Care.
2. I agree to be contacted via email or SMS with information related to my visit, like: a patient portal invitation, post-visit satisfaction survey, appointment or checkup reminders, health tips, or new services that relate to me or my family.
3. I authorize payment of medical benefits to Doctors Care physicians or their designee for services rendered.

I have received a copy of the Notice of Privacy Practice and Financial Policy Notice. ☐ Yes ☐ No Initials: _____

Patient or authorized person's signature	Date