Patient Information and Consent

Please Print

What is the reason for your visit today? _____

Have you been treated at any Doctors Care office location before? ☐ **Yes** ☐ **No** - If "Yes" please complete line 1 (bolded) below, update any information that has changed since your last visit and sign the Patient Consent for Treatment section on page 2. Copy of insurance card is required for all visits.

Patient Information

Name (First, Middle, Last)	**Birth Date**	**Age**	**Social Security #**	**Sex:** ☐ **M** ☐ **F**

Address	Apt. #	City	State	Zip

Email Address (We will never rent or sell your email address – we value your privacy.)

Home Phone Okay to leave voice message? ☐ Yes ☐ No	Cell Phone Okay to leave voice message? ☐ Yes ☐ No

Employer (or Parent's Occupation if minor)	Work Phone

Responsible Party or Parent's Name (if minor)	Guarantor Birth Date	Guarantor Social Security #

Preferred Language

ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Emergency Contact

Name	Relationship	Home Phone	Cell Phone

Address	City	State	Zip	Email Address

Preferred Pharmacy

Do you use the Doctors Care In-Center Pharmacy? ☐ Yes ☐ No - *Ask about Aidarex*

Pharmacy Name	Pharmacy Location

Insurance | Please present your insurance card to the receptionist.

PRIMARY INSURANCE CARRIER			**SECONDARY INSURANCE CARRIER**		
Insurance Company Name			Insurance Company Name		
Address			Address		
City	State	Zip	City	State	Zip
Phone	Policy Number		Phone	Policy Number	
Group Number / Name			Group Number / Name		
Insured Name & DOB			Insured Name & DOB		
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent			Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent		

Workers' Compensation

Not Applicable ☐

IS THIS A WORKERS' COMPENSATION CLAIM? ☐ Yes ☐ No

Workers' Compensation Billing Address

I hereby authorize Doctors Care to speak to a rehabilitation specialist, my employer, my insurance carrier or other professionals involved in my care of rehabilitation, regarding my medical records and the treatment I have received or will receive.

X _____ _____

Patient or Authorized Person's Signature | Date

Accident/Injury Information (if applicable)

Not Applicable ☐

Where did the injury occur? (example: park) _____

Were you struck by an object? ☐ Yes ☐ No If Yes, what type of object? _____

Where did you fall? (example: kitchen, bathroom, garage) _____

Where did you fall from? (example: ladder, roof, steps) _____

If you were in a motor vehicle accident, were you the driver or passenger? _____

Authorization for Release of Information

Can we leave results to internal and external office testing or referrals in email or voicemail? ☐ Yes ☐ No

Whom can receive information on your behalf regarding testing or referrals? Name: _____

Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedures 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 consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Doctors Care Notice of Privacy Practices.
3. I authorize payment of medical benefits to Doctors Care physicians or their designee for services rendered.
4. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

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

X _____ _____

Patient or Authorized Person's Signature | Date

FOR INTERNAL USE ONLY

DocuTAP Visit ID: _____ Co-Pay Collected: $ _____