If you have visited Doctors Care within the past year, you are an

Existing Patient

Patient Information and Consent

What is the reason for your visit today? _____

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.)	Cell Phone Okay to leave voice message? ☐ Yes ☐ No

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		

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: _____

Workers' Compensation

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

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

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

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