# New Patient Information and Consent

## What is the reason for your visit today?

## Patient Information

| Name (First, Middle, Last) | Birth Date | Age | Social Security # |
|---|---|---|---|
| | | | |

| Birth Sex ☐ M ☐ F | Primary Care Provider | ☐ None ☐ Doctors Care is my primary care provider |
|---|---|---|
| | | |

| Mailing Address | Apt. # | City | State | Zip |
|---|---|---|---|---|
| | | | | |

| Email Address | Primary Phone | ☐ Home ☐ Cell | Okay to leave message? ☐ Yes ☐ No |
|---|---|---|---|
| | | | |

| Employer (or parent's employer if patient is a minor) | Work Phone |
|---|---|
| | |

| Preferred Language | **RACE** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White |
|---|---|
| **ETHNICITY** ☐ Hispanic or Latino ☐ Not Hispanic or Latino | |

| **EMERGENCY CONTACT** | Name | Relationship | Primary Phone |
|---|---|---|---|
| | | | |

## Guarantor (Person responsible for payment)

| Guarantor's Name | Guarantor Birth Date | Guarantor Social Security # |
|---|---|---|
| | | |

## Preferred Pharmacy

Are you interested in using the Doctors Care In-Center Pharmacy? ☐ Yes ☐ No

| Pharmacy Name | Pharmacy Location |
|---|---|
| | |

## Insurance | Please present your ID and 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

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

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

Who may 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 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 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.
4. I authorize payment of medical benefits to Doctors Care physicians or their designee for services rendered.
5. 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: $ _____