



Established Patient Information and Consent

What is the reason for your visit today?	
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Patient Information				
Name (First, Middle, Last)	Birth Date	Age	Social Security #	Birth Gender <input type="checkbox"/> M <input type="checkbox"/> F
Mailing Address	Apt #	City, State ZIP		
Email Address	Primary Phone	<input type="checkbox"/> Home <input type="checkbox"/> Cell	Okay to leave message?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care Provider (where you go for your routine medical care)			<input type="checkbox"/> None <input type="checkbox"/> Doctors Care is my primary care provider	
Emergency Contact Name	Emergency Contact Phone	Relationship to Patient		

Preferred Pharmacy	Are you interested in using the Doctors Care In-Center Pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Pharmacy Name	Pharmacy Location

Medical Insurance (please present your ID and insurance card to the receptionist)		
PRIMARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
Insurance Company Address (usually on back of insurance card)		Phone

SECONDARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
Insurance Company Address (usually on back of insurance card)		Phone

Authorization for Release of Information	
May we leave testing results or referral info in email or voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	Who may receive information on your behalf regarding testing or referrals? Name: _____

Patient Consent for Treatment

- 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.
- 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.
- 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.
- I authorize payment of medical benefits to Doctors Care physicians or their designee for services rendered.
- 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: \$	_____