# 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 Gender ☐ M ☑ F |
|---|---|---|---|---|---|
| Mailing Address | Apt # | City, State ZIP | | | |
| Email Address | | Primary Phone ☐ Cell ☐ Landline | Okay to leave message? ☐ Yes ☐ No | | |
| Employer (or parent/guardian employer if patient is a minor) | | | | Work Phone | |
| Email | | | | | |
| Preferred Language | | Race ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Island ☐ Other ☐ American Indian/Alaska Native ☐ Prefer not to answer | | | |
| Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino | | | | | |

**Emergency Contact**

| Contact Name | Phone Number | Relationship to Patient |
|---|---|---|
| | | |

**Guarantor/Responsible Party** (person responsible for payment)

| Legal Name of Responsible Party (First, Middle, Last) | Cell Phone # | Date of Birth |
|---|---|---|
| | | |

**Preferred Pharmacy**

| 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 ☐ Self ☐ Spouse ☐ 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 ☐ Self ☐ Spouse ☐ Dependent |
| Insurance Company Address (usually on back of insurance card) | | Phone |

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## Workers' Compensation

**Is your visit today for a workers' compensation claim?** ☐ Yes ☐ No

Worker's Compensation Billing Address

I hereby authorize Bliss Medical Center 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 Bliss Medical Center 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 Bliss Medical Center.
2. I agree to be contacted via email or text with: information related to my visit, 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 Bliss Medical Center HIPPA Notice of Privacy Practices.
4. I authorize payment of medical benefits to Bliss Medical Center 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 received a copy of the HIPPA Notice of Privacy Practice & Financial Policy Notice. ☐ Yes ☐ No Initial _____

X _____ _____

Patient or Authorized Person's Signature Date

**FOR INTERNAL USE ONLY**

Visit ID: _____ Co-Pay Collected: $ _____