



## New Patient Information and Consent

<b>What is the reason for your visit today?</b>

<b>Patient Information</b>					
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
Employer (or parent/guardian employer if patient is a minor)				Work Phone	
Primary Care Provider (where you go for your routine medical care)					<input type="checkbox"/> None <input type="checkbox"/> Other <input type="checkbox"/> Pro Salud Medical Center
Preferred Language		Race <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Prefer not to answer			
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino					

<b>Emergency Contact</b>		
Contact Name	Phone Number	Relationship to Patient

<b>Guarantor/Responsible Party</b> (person responsible for payment)		
Legal Name of Responsible Party (First, Middle, Last)	Social Security #	Date of Birth

<b>Preferred Pharmacy</b>	
Pharmacy Name	Pharmacy Location

<b>Medical Insurance</b> (please present your ID and insurance card to the receptionist)		
<b>PRIMARY</b> 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
<b>SECONDARY</b> 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

<b>Workers' Compensation</b>	<b>Is your visit today for a workers' compensation claim?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
Worker's Compensation Billing Address _____	
I hereby authorize Pro Salud 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

<b>Accident/Injury Information</b>	Not Applicable <input type="checkbox"/>
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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? \_\_\_\_\_

<b>Authorization for Release of Information</b>
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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: \_\_\_\_\_

<b>Patient Consent for Treatment</b>
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1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Pro Salud 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 Pro Salud Medical Center.
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 Pro Salud Medical Center Notice of Privacy Practices.
4. I authorize payment of medical benefits to Pro Salud 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 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