PATIENT REGISTRATION

ESSENTIAL med clinic FAMILY MEDICINE AND MEDICAL WEIGHT LOSS

Patient Name: _____ **Birthdate (MM/DD/YYYY):** _____

Gender: M ☐ F ☐ **Marital status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Street Address: _____

(City/State/Zip): _____

Social Security #: _____ **Email Address:** _____

It is advised that you provide a private email address to which only you have access. For information about our Privacy Policy, please refer to: **Essential Med Clinic**

☐ **I consent to receive emails from Essential Med Clinic, other than those that come from the Patient Portal. I understand that these emails will be informational in nature, not contain any personal or confidential information and that I can click "Unsubscribe" at the bottom of any email to stop receiving them.**

Tel. No.: Work: _____ **Home:** _____ **Cell:** _____

Caregiver: _____ **Phone:** _____

If student, school name: _____

What is the preferred language to receive information?

English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Other: ☐ _____

Race: Native Hawaiian or Other Pacific Islander ☐ African American ☐ Asian ☐ Hispanic ☐ White ☐
European ☐ Other Race ☐ Refuse to report ☐

How did you hear about this clinic?

Current Patient ☐ Family/Friend ☐ Clinic Event ☐ Health Plan and/or Representative ☐ Community Event ☐
Advertisement ☐ Unavailable/Unknown ☐ Other: ☐ _____

PATIENT EMPLOYER INFORMATION

Employer Name: _____
Employer Address / Work No.: _____

Patient's Occupation:_____

INSURED PERSON (IF NOT PATIENT)

Name:_____ Birthdate (MM/DD/YYYY):_____

Tel.No.: Work:_____ Home:_____ Cell:_____

Street Address:_____ City/State/Zip:_____

EMERGENCY CONTACT

Name:_____ Birthdate (MM/DD/YYYY):_____

Tel.No.: Work:_____ Home:_____ Cell:_____

Street Address:_____ City/State/Zip:_____

INSURANCE

Do you have military benefits? Yes ☐ No ☐

Primary Insurance Company:_____ Phone:_____

Address: _____

Group #: _____ Plan:_____ Certificate or ID#_____

Insured's Name:_____ Relationship to patient: self /spouse/ Dependent

Insured's Employer:_____ Phone #:_____

Employer Address: _____

Secondary Insurance Company: _____ ID#: Plan: Group:

Insured's Name:_____ Relationship to patient: self/spouse/Dependent

Insured's Employer:_____ Phone #

AUTHORIZATION TO RECEIVE EXTERNAL PRESCRIPTION HISTORY

I hereby authorize Essential Med Clinic and its affiliated providers to electronically retrieve my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions that date back several years.

I understand that Essential Med Clinic and its affiliated providers will use my external prescription history to: provide me with medical treatment, evaluate and improve the safety of their patients and improve the quality of medical care provided to me. I understand that I can revoke my permission at any time by giving written notice to my provider.

Signature of Patient or Legal Representative:_____ Date:_____

PHARMACY INFORMATION

Preferred Pharmacy:_____

Address:_____

Phone:_____

ASSIGNMENT OF BENEFITS

I hereby authorize Essential Med Clinic to apply for benefits, on my behalf, for covered services. I request that payment from my insurance company be made directly to Essential Med Clinic. I certify that the information I have reported with regard to my insurance coverage is correct.

I understand that I am responsible for payment of all medical services rendered. Any checks sent to me by my insurance company will be forwarded to this medical group to apply to my account, should a balance exist.

Signature of Patient or Legal Representative:_____ Date:_____

CONSENT TO TREAT

I, the undersigned, as/on the behalf of the patient, do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician on duty.

Signature of Patient or Legal Representative:_____ Date:_____

CONSENT FOR PHOTOGRAPHY, VIDEO/RECORDINGS

(Images taken for the purposes of treatment, payment and/or health care operations)

I consent to have my image taken by Essential Med Clinic for use of treatment, payment or healthcare operations. I understand that my image, including photographs, etc. will used be for the purpose of assisting my treatment or healthcare operations including quality initiatives. I understand that Essential Med Clinic will own these images. I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information prior to the written notice of withdrawal.

I certify this form has been fully explained to me and I understand its contents.

Signature of Patient or Legal Representative: _____ **Date:** _____