Office Use Only ☐ NEW PATIENT ☐ ESTABLISHED ☐ UPDATE

IMPERIAL VALLEY FAMILY CARE MEDICAL GROUP, APC

PATIENT INFORMATION

DATE: ____________________ DOCTOR: ____________________

ACCOUNT ________________ **PLEASE PRINT**

LAST NAME FIRST MIDDLE

STREET ADDRESS CITY STATE ZIP CODE

DATE OF BIRTH: AGE: SOC SEC #:

Sex Assigned at Birth ☐ Female ☐ Male ☐ Intersex ☐ Other

MARITAL STATUS
☐ Single ☐ Married ☐ Widowed ☐ Divorce
☐ Registered Domestic Partner ☐ Unmarried Partner ☐ MINOR *

Gender Identity ☐ Female ☐ Male ☐ Intersex ☐ Other
☐ Prefer Not to Say

Pronouns: ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs
☐ Other

Transgender ☐ Yes ☐ No
Transgender ☐ Woman ☐ Man ☐ Transgender Woman/Trans Feminine
☐ Transgender Man/ Trans Masculine ☐ Non-Binary
Genderqueer/Gender Fluid
☐ Two Spirit ☐ Prefer to self-describe ________________
☐ Prefer not to say

RACE (Circle):Am Indian / Alaska Native / Asian / Black / White / Hispanic / Other Race / None Reported

ETHINICITY (Circle): Hispanic / Non-Hispanic / Refuse to Report

LANGUAGE PREFERENCE (Circle): English / Spanish / Indian / Other

Home Phone #: ____________________

Cellular Phone #: ____________________

Message or Business #: ____________________

EMAIL: ____________________
☐ **I do not have one**

EMERGENCY CONTACT - (Name & Address of Relative or Friend Not Living With You)

____

TELEPHONE: ____________________

PHARMACY INFORMATION

Name ____________________

Address ____________________

____

REFERRED TO PROVIDER BY:

PLEASE PRESENT YOUR CURRENT INSURANCE CARD(S) TO THE RECEPTIONIST

FINANCIAL RESPONSIBILITY PARTY ☐ **PATIENT IS A MINOR – PARENT INFORMATION**

LAST NAME FIRST NAME SOCIAL SECURITY DATE OF BIRTH RELATIONSHIP TO PATIENT

ADDRESS HOME PHONE CELL PHONE EMPLOYER ADDRESS

FINANCIAL AGREEMENT

- I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE ABOVE NAMED PATIENT
- I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS TO THE REFERRING OR PRIMARY CARE PHYISICIAN AND TO MY INSURANCE COMPANY, MEDICARE OR MEDICAID, IF APPLICABLE
- I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR ALL SERVICES RENDERED BY THE PHYSICIAN AND AUTHORIZE TRANSFER OF ALL UNPAID AMOUNTS TO MY ACCOUNT FROM THE DATE OF SERVICE(S)
- I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER DEFINITE FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT
- I FURTHER AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO IMPERIAL VALLEY FAMILY CARE MEDICAL GROUP, APC.

SIGNATURES ______________________________ **DATE:** ______________