Gutrierrez Family Medicine

New Patient Intake Form

We'd like to welcome you as a new patient. Please take the time to fill out this form as accurately as possible so that we can most appropriately address your health needs.

While this clinic recognizes differences in gender identities, sex and sexual orientation; many insurance companies and legal entities do not. Please understand that the legal name and sex listed on your insurance must be used on document pertaining to insurance and billing. If your preferred name and pronouns are different from these, please let us know.

Please print all responses:

Legal Name:_____ **DOB:**_____ **Preferred Name:**_____

Address:_____ **City:**_____ **Zip:**_____

Phone:_____ **is it ok to leave messages ?** Y/N Yes [ ] No [ ]

Sex: Male, Female, Intersex, Transgender Female-to-male or Male to Female, Questioning (circle one)

Do you work outside the home? If yes where_____

Incase of an emergency who should we contact?

Name:_____ Phone:_____ Relationship:_____

Can we talk to this person about the following: Billing Health Issues Appointments Emergency (circle all that apply)

Name:_____ Phone:_____ Relationship:_____

Can we talk to this person about the following: Billing Health Issues Appointments Emergency (circle all that apply)

Please list ALL Active treating Physician (i.e. pulmonologist, oncologist, internist, cardiologist, etc...)

Doctors name:_____ Specialty:_____

Doctors name:_____ Specialty:_____

Doctors name:_____ Specialty:_____

Doctors name:_____ Specialty:_____

Do we have permission to contact these doctors to coordinate you care? Y or N Yes [ ] No [ ]

Please note our office does not see patients for workers compensation or Auto accidents. Our office is a opioid free clinic we will do whatever we can to treat your pain however we do not prescribe opioids we do refer to pain management if this is something you feel you need.

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits to be paid directly to Gutierrez Family Medicine for services rendered. I authorize representatives of Gutierrez Family Medicine to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

I have read all the above. The information above is correct as possible and I agree to the terms of the Patient Financial Obligation Agreement.

Patient or legal guardian name (print):_____

Patient or legal guardian signature:_____ Date:_____