DOCTORS ON DUTY™ MEDICAL + CLINICS

Patient Information:

Last Name:	First Name:	Middle Initial:
Gender: Social Security#: - -	Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Other:	
Birthdate: / /	Race: Ethnicity:	Primary Language:
Mailing Address:	Zip: City:	State:
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )
By providing my cell phone number, I consent to Doctors on Duty Medical Clinics, including its business associates, calling and/or texting regarding appointments and to call regarding my care and/or payment of my care. Other federal and state rules govern telemarketing and commercial email messages. A summary of these laws is available on the website of the Office of the Attorney General at oag.ca.gov/privacy/privacy-laws		
Email Address (Required):	Name of your Primary Care Physician:	
Preferred Pharmacy:	City:	Street:

If Patient Is A Minor Please Complete:

Name of Parent/Guardian:	Guarantor Date of Birth:	
Mailing Address:	Zip: City:	State:
Social Security#:	Relationship to Patient:	Phone:

Primary Insurance Name:

Name of Insured:	Date of Birth:	Social Security #:
Relationship to Insured:		

Secondary Insurance Name:

Name of Insured:	Date of Birth:	Social Security #:
Relationship to Insured:		

Person to Notify in Case of Emergency:

Name (Not in Same Household):		
Street Address:	Zip:	City:
Home Phone:	Relation to Patient:	

Please describe your illness/injury/symptoms and date of onset: ____

____ **Work Related:** Yes ____ No ____

Release of Information and Financial Responsibility

We request payment at the time of service. We are contracted with some insurance carriers and may be able to bill directly for you. Please provide us with a copy of your insurance card. If a co-payment/deductible is part of your plan, we require that your portion is paid at the time of service. We will make every effort to provide you with the accurate amount due at the end of your visit today. However, your medical and billing records will be reviewed within 1-2 business days of your visit. If there are any discrepancies in the coding and billing, you will receive an additional bill or a refund if overcharged.

Doctors on Duty Medical Clinics and affiliates, in compliance with the California Business and Professions Code, hereby notify you of your right to either have your prescription filled by our medical provider or of obtaining a written prescription for filling at a pharmacy of your choice. Please advise the prescribing provider if you elect NOT to have your prescription filled and a written prescription will be provided to you.

I hereby authorize the release of any medical information to insurance carriers needed to process a claim and request payment be sent to Doctors on Duty for medical services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance, and that I will be expected to pay if insurance has not paid within 60 days. I agree to a $25.00 service charge on any check I present which is returned unpaid. I hereby consent to treatment at Doctors on Duty Medical Clinics.

Patient email Address

By providing my email address, I give Doctors on Duty permission to email me directly or through a third party to survey me regarding my visits for the purpose of patient satisfaction and quality assessment. Doctors on Duty will not share my email address or medical records with others.

Lab Service Disclosure

Please be advised that Laboratory Services are provided by Quest, Salinas Valley Memorial Hospital Laboratory, and/or another outside laboratory. If you wish to select a laboratory other than the ones mentioned, please inform the medical staff. The lab that receives your specimen(s) will bill you separately for its services.

Signature: ______________________ **Relationship:** ____________________ **Date:** ____________