AllCare
Primary Care & Walk-ins

PATIENT INFORMATION

Patient's Name: _____ Date of Birth:_____
☐ Married ☐ Single ☐ Other Sex: ☐ Male ☐ Female
NAME OF RESPONSIBLE PERSON (if patient is a minor):_____
RACE: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Black/African American
☐ White ☐ Hispanic ☐ Other Race
ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Refused to Report
LANGUAGES: ☐ English ☐ Other ☐ Indian (includes Hindi &Tamil) ☐ Spanish ☐ Russian
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone _____ Cell Phone/Message _____
E-Mail Address:_____; confirm address: _____
Patient's Social Security Number (if a Minor, the Responsible Party) (SSN):_____

Detailed Messages (appointments, call back, labs, results, etc) may be left at Home ☐ Cell Phone ☐

Patient Portal AllCare Web Communication (requires additional office setup) communications consent initial Yes or No: (Yes)_____ or (No)_____

Employer: _____ Phone: _____

Are you currently using Health Insurance: ☐ Yes ☐ No
Name of Primary Insurance Company: _____
Group #: _____ ID # _____
Secondary Insurance Company (if applicable) _____

Do you have a Living Will? ☐ Yes ☐ No DNR/DNI: _____ Other Specific Code Status _____

Durable Medical Power of Attorney: _____ Guardianship: _____

POLICY INFORMATION:
Employer: _____ Phone: _____
Employer's Address: _____
Employee: _____ SSN: _____
Relationship to Patient: _____ Date of Birth(mm/dd/yy) _____ Sex: ☐ Male ☐ Female
EMERGENCY CONTACTS:
Primary Emergency Contact Name: _____
Relationship to Patient: _____Phone: _____
Secondary Emergency Contact Name: _____
Relationship to Patient: _____Phone: _____
Do you have a doctor you see on a regular basis (PCP)?If so, whom; PLEASE LIST EVEN IF OUT OF STATE

Name: _____ Phone: _____
How did you hear about AllCare? Who may we thank for your referral? CHECK ALL THAT APPLY
☐ Friend ☐ Work ☐ Hotel ☐ Drive By ☐ Co-Worker ☐ Newspaper ☐ Phone ☐ Other _____

Patient Signature _____ Date_____

Legal Guardian/Representative Signature (if Minor) _____Date_____