COMPREHENSIVE
PRIMARY CARE

Name _____ Date of Birth _____
Marital Status ❑Married ❑Single ❑Widowed ❑Divorced Gender ❑Male ❑Female
Mailing Address _____
Phone Numbers Home _____ Cell _____ Work _____
Primary Phone Is ❑Home ❑Cell ❑Work Email Address: _____
Primary Language ❑English ❑Arabic ❑Chinese ❑French ❑Hindi ❑Portuguese ❑Russian
❑Spanish ❑Vietnamese ❑Other: _____
Race ❑American Indian/Alaskan Native ❑Asian ❑Black/African American ❑Native Hawaiian/Pacific Islander
❑White ❑Other Race ❑Unknown ❑Declined
Ethnicity ❑Hispanic or Latino ❑Non-Hispanic or Latino ❑Declined

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Employer _____
Employer Address _____ Phone _____

EMERGENCY CONTACT
Spouse, companion, relative or friend living with you
Name & Relationship _____ Daytime Phone _____

Nearest relative or friend not living with you
Name & Relationship _____ Daytime Phone _____

INSURANCE INFORMATION
Primary _____ Policy # _____ Group # _____
Name of Insured & Relationship _____ DOB _____

Secondary _____ Policy # _____ Group # _____
Name of Insured & Relationship _____ DOB _____

Tertiary _____ Policy # _____ Group #_____
Name of Insured & Relationship _____ DOB _____

PREFERRED PHARMACY INFORMATION
Pharmacy Name _____ Pharmacy Phone: _____
Pharmacy Address _____

How did you hear about us? ❑Google ❑Facebook ❑Friend/Family ❑Specialist/ Other Dr. ❑Other
I authorize CPC to communicate with my pharmacy to obtain my prescription history. ❑ Yes ❑No

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I certify that the above information is correct. I consent to be treated by the staff and providers of CPC and its affiliates. I authorize payment of medical benefits to CPC and its affiliates, and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services. In order to maintain continuity of care, I give permission to CPC to release my medical records to any specialists, hospitals or medical facilities associated with my care plan. I understand that CPC abides by HIPAA regulations and that only the records pertinent to the visit will be released.

Patient/Guarantor Signature _____ Date _____