THE DO DOCTORS

FREE PRIMARY CARE AT OUR OFFICE, YOUR ASSISTED LIVING & HOME
PHONE : (951) 925-3635 FAX : (951) 925-0014
EMAIL : DOCARE@THEDODOCTORS.COM
2569 W. Florida Ave. Hemet CA. 92545

New Patient Sign-Up Notice & Agreement

Biographical Information Data Sheet Patient Information.

(Please complete this form, Sign & return it to the office via fax, email, or in person.

Facility Name:_____. Building # _____. R#_____.**Today's Date**:_____.

Last Name _____. **First Name**:_____.

D.O.B:_____. **Height/Weight**____/____. **Address**:_____ **City**:_____

Phone:_____.**Email**:_____.

MEDICATION ALLERGIES:____(** Section Required If None Write KNA or Check the Box **)_____: **NO Allergies?** ☐

POA :_____POWER OF ATTORNEY_____ . **Relation**:_____. **Phone**: _____.

Authorization of Treatment and Agreement of Consultation

I ____Patient/Guardian Name/Sig____, hereby, consent to and authorize the administration of all diagnostic and therapeutic treatment advisable according to the judgment from the providers of The Offices of Dr. David Perz, D.O. & The DO Doctors.

I ____Patient/Guardian Name/Sig____, hereby agree to notify and discuss with The Offices of Dr. David Perz, D.O. & or The DO Doctors assigned provider ***prior to* use *of or agreement to use* ANY** healthcare services or products. I understand that change of my healthcare plan without discussion with my doctor can place me or the one I am guardian over at risk. Therefore, I agree to discuss healthcare decisions such as *HOSPICE, ALTERNATIVE TREATMENT,* or any other changes with The Offices of Dr. David Perz, D.O. & or The DO Doctors assigned provider prior to accepting treatment.

Patient Acknowledgement of Notice of Privacy Practices

I _____Patient/Guardian Name/Sig_____, understand that my Doctors, Clinicians, The Offices of Dr. David Perz, D.O. & The DO Doctors has certain legal duties to protect my Protected Health Information (PHI), and I have certain rights regarding my PHI.

Authorization to release information

I _____Patient/Guardian Name/Sig_____, Give permission to release medical information to _____(Person you want given Health updates)_____, Dr. David Perz, D.O. & The DO Doctors. By signing, I also give The Offices of Dr. David Perz, D.O. & The DO Doctors, permission to send & receive any information purposed to provide health care. Specifically, please request medical records from:

_____Facility name/ Dr. Name_____. : :_____Facility name/ Dr. Name_____.

Patient/Guardian Name:_____PRINT Patient/Guardian Name_____. **D.O.B**: _____.

Patient's/Guardian's Signature:_____SIGNATURE of Patient/Guardian Name_____. **Date.** _____.

PLEASE EMAIL OR FAX YOUR MEDICATION LIST, INSURANCE & ID!