Mission Primary Care

3755 Beacon Ave, Fremont, CA 94538 · 1090 La Playa Drive, Hayward, CA 94545 · 15921 E 14th St, San Leandro, CA 94578

Phone 510-796-7796 · Fax 510-796-7797 · www.m-primarycare.com

NEW PATIENT REGISTRATION

PATIENT INFORMATION

First name

Middle name (optional)

Last name

Date of birth

mm/dd/yyyy

Preferred language

Interpreter needed?

◯ Yes ◯ No

Sex assigned at birth

◯ Male ◯ Female ◯ Intersex ◯ Decline to answer

Street address

City

State

ZIP

Email

Preferred clinic

◯ Fremont ◯ Hayward ◯ San Leandro ◯ No preference

CONTACT INFORMATION

Main phone

Alternate phone (optional)

Best way to reach you

- ◯ Phone call
- ◯ Email
- ◯ Text message (see consent below)

Previous primary care provider (optional)

Their phone (optional)

EMERGENCY CONTACT

Full name

Relationship

Phone

Alternate phone (optional)

PHARMACY

Pharmacy name

Phone

Address or location

INSURANCE

Primary insurance or medical group

Group number

Member ID

Policy holder name

Policy holder's relationship to patient

- ◯ Self
- ◯ Spouse
- ◯ Other

Secondary insurance (optional)

Member ID (optional)

Paying without insurance?

- ◯ Yes, self-pay
- ◯ No

HEALTH HISTORY

Current medications

Include over-the-counter medicines, vitamins and supplements, with the dose and how often you take each. Write “None” if you take none.

Allergies

Food, drug and environmental allergies, and the reaction each causes. Write “None” if you have none.

Medical conditions

For example high blood pressure, diabetes, asthma, heart disease, depression.

Surgeries and hospital stays

What, and roughly when (month and year).

CONSENT FOR COMMUNICATION

I authorize Mission Primary Care to contact me by telephone and email at the numbers and address I have given about my appointments, test results, billing and account matters, and the coordination of my care. Text messaging is a separate, optional service — see below.

TEXT MESSAGING (SMS) CONSENT — OPTIONAL

This consent is optional. It is not a condition of treatment, of purchase or of receiving any service. Leaving the box unchecked will not affect your care in any way, and you can withdraw consent at any time by replying STOP.

Mobile number for text messages

☐ I agree to receive text messages from Mission Primary Care about my appointments, care follow-up, prescriptions, and billing or account updates at the mobile number provided. Message frequency varies. Msg & data rates may apply. Reply STOP to opt out, HELP for help. Consent is not a condition of treatment.

Your mobile number and text messaging consent will not be sold or shared with third parties or affiliates for marketing or promotional purposes.

Read our **Privacy Policy** (www.m-primarycare.com/privacy-policy) and **Terms & Conditions** (www.m-primarycare.com/terms) for full details of the text messaging program.

NOTICE OF PRIVACY PRACTICES

☐ I acknowledge that I have been offered a copy of the Mission Primary Care Notice of Privacy Practices, which describes how my health information may be used and disclosed.

SIGNATURE

By signing below, I confirm that the information on this form is accurate to the best of my knowledge. If you are completing this form as the patient's legal representative, give your relationship to the patient.

Printed name

Relationship to patient, if not self (optional)

Signature

Date

mm/dd/yyyy