

CONTACT INFORMATION

Name: _____

Preferred Name: _____

Date of Birth (DOB): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Sex Assigned at Birth: Male Female

Preferred Pronouns: He/Him/His She/Her/Hers They/Them/Their

Phone Number: _____

Email Address: _____

Can **Chaparral Medical Group** leave a voicemail on the phone number listed above?

Yes No

Can **Chaparral Medical Group** text* you on the phone number listed above?

Yes No

*By checking "Yes", I consent, as applicable, to receive SMS/text messages/emails from Chaparral Medical Group regarding my care, appointment scheduling and reminders, new programs or services we might be offering, instructions, healthcare-related marketing materials, educational content, new service announcements and general information. Message frequency may vary. Msg & Data Rates May Apply. I understand I can reply STOP to opt out or HELP for more information

Can **Chaparral Medical Group** email * you at the email address listed above?

Yes No

*Email transmission can involve security risks (for example, interception or unauthorized access).

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

Can **Chaparral Medical Group** share medical information with this person?

Yes No

Marital/Family Status (Optional)

Marital Status: Single Married Partnered Divorced Widowed
 Prefer not to say

Insurance

Insurance Provider: _____ Member ID Number: _____

I do not have insurance

Race & Ethnicity (Optional)

Race (Select all that apply):

- American Indian or Alaska Native
- Asian – please specify (e.g., Bangladeshi, Chinese, Indian, Pakistani, Filipino, etc.): _____
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Middle Eastern or North African
- Other: _____
- Prefer not to say

Ethnicity (Optional)

- Hispanic or Latino/a/x
- Not Hispanic or Latino/a/x
- Prefer to self-describe: _____
- Prefer not to say

Other (Optional)

Housing Status: Stable Housing Unstable Housing Unhoused
 Prefer not to say

Are you a Veteran? Yes No

Disability Status: _____

ACKNOWLEDGEMENT AND CONSENT

SIGNATURE PAGE

I confirm that I have received and read the patient documents. I had the opportunity to ask questions, and if I asked questions, my questions were answered to my satisfaction.

By signing below, I acknowledge my understanding of the patient documents and give my consent for the documents listed below.

- Consent to Treat and Acknowledge Services
- Use of Transcription and Artificial Intelligence (AI) Tools
- Patient Rights and Responsibilities
- HIPAA Notice of Privacy Practices
- Non-discrimination Consent Acknowledgement
- Telehealth Consent
- Patient Financial Responsibility Form

Print Patient Name

Patient Date of Birth

Patient or Representative Signature

Date

Relationship to patient