



**PATIENT INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Facility Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Gender:  Male  Female SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_  
 Primary Language: \_\_\_\_\_ Marital Status: \_\_\_\_\_

**RESPONSIBLE PARTY**

Relationship to Patient: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Responsible Party is also the Emergency Contact?**  Yes  No

*(Please list additional contact(s) below if applicable)*

Relationship to Patient: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Consent for Communicating PHI via Text (SMS) and Voicemail**

*(By checking the following boxes, you acknowledge your consent)*

- I give my consent to receive text (SMS) messages at the mobile number(s) provided.
- I give my consent to receive detailed information regarding my account (scheduling appointments, billing issues, etc.) on my voicemail at the phone number(s) provided.

**PRIMARY - Medical Insurance Information**

Relationship to Insured:  Self  Spouse  Other: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_  
 Member ID: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**SECONDARY - Medical Insurance Information** *(if applicable)*

Relationship to Insured:  Self  Spouse  Other: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_  
 Member ID: \_\_\_\_\_ Effective Date: \_\_\_\_\_

- I choose to utilize Gateway Medical as my preferred primary care provider.
- I choose to utilize Gateway Medical for acute needs only and will contact my current primary care provider for other needs and medication refills.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date