Welcome

Patient Full Name _____

Thank you for choosing Seniority Healthcare. We are honored to be your trusted partner in health and well-being. Our dedicated team is committed to providing the highest quality of care with compassion and excellence.

At Seniority Healthcare, we understand that choosing a healthcare provider is a significant decision, and we are grateful for the trust you have placed in us. Our mission is to ensure that you receive the best possible care tailored to your unique needs. We pride ourselves on our holistic approach, integrating on-site primary care, telehealth support, care coordination, and integrated behavioral health services.

We look forward to supporting you on your healthcare journey!

Tips for completing the New Patient Intake Forms

- **Please include a copy of all insurance cards (front and back) *required***
- Write clearly and legibly (These forms are also available to be completed online!)
- Print an additional page if extra space is needed
- If available, include a copy of any Advanced Directives
- **Medical Release Form (pg 8) only fill in the following**:
    - Patient Name and Date of Birth (top of the page)
    - Print/Sign (bottom of the page)
    - *Leave the middle portion blank*

If you have any questions or concerns please do not hesitate to reach out! We can be reached at 888-982-8594 Monday thru Friday (8am-4pm) or via email: hello@senioritythealthcare.com

Additional Helpful Info

Website: senioritythealthcare.com
Fax: 888- 920-1525

Seniority HEALTHCARE

Demographics

Patient First Name	Patient Middle Name	Patient Last Name	Patient Preferred Name
Home Phone	**Cell Phone**	**Email**	
Social Security Number	**Date of Birth**	**Age**	**Sex** M F

Marital Status	Race	Ethnicity
☐ Married ☐ Widowed ☐ Divorced ☐ Single	☐ White ☐ Black/African American ☐ Asian ☐ American Indian ☐ Pacific Islander ☐ Other	☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Other

Street Address	City	State	Zip

Emergency Contact

First Name	Last Name
Relationship	**Phone Number**

Insurance

Primary Insurance Info

Please include copies of your insurance cards (front/back)

Policy Holder

- ☐ Self
- ☐ Spouse
- ☐ Other (please specify) _____

First Name	Last Name	Date of Birth	ID #
_____	_____	_____	_____

Insurance Company Name	Group Name	Group Number
_____	_____	_____

Relationship to Patient

- ☐ Self
- ☐ Spouse
- ☐ Other (please specify)_____

Secondary Insurance Info

Policy Holder

- ☐ Self
- ☐ Spouse
- ☐ Other (please specify) _____

First Name	Last Name	Date of Birth	ID #
_____	_____	_____	_____

Insurance Company Name	Group Name	Group Number

Relationship to Patient

- ☐ Self
- ☐ Spouse
- ☐ Other (please specify)_____

Patient Full Name _____ **Date** _____

Patient/Legal Representative Signature

Seniority HEALTHCARE

Medical History (Page 1 of 2)

Name of Current Physician	Phone	Date of Last Visit
_____	_____	_____

Current Diagnosis List (Name/Year Diagnosed)

1	6
2	7
3	8
4	9
5	10

Any Other Medical Conditions Not Listed Above?

_____

Are You Being Treated For Cancer of Any Kind?

_____

Have You Ever Been Hospitalized? When?

_____

_____

_____

Have You Ever Experienced An Adverse Reaction During Medical Treatment?

_____

List Any Specialists You See Regularly

_____

Medical History (Page 2 of 2)

List All Medications You Are Now Taking (Please Include Over-the-counter Vitamins, Herbs, Pain Relievers) - A Med List May Be Attached

List Any Drug or Food Allergies + Reaction

May I Have Your Permission To Speak Directly With Your Physician(s) Regarding Your Treatment? (Circle One)

YES **NO**

I, with my signature, attest that I have reviewed the information on this medical history form and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate and healthful treatment. If there is any change in my medical status, I will inform the doctor. I authorize the insurance company indicated on this form to pay to the doctor all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance

Patient Full Name _____ **Date** _____

Patient/Legal Representative Signature

Consent (Page 1 of 2)

I, with my signature, authorize (this practice) and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but is not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, management of chronic diseases, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other healthcare professionals for care and treatment. In addition, I understand if I am eligible and it is medically necessary, I will be enrolled in the Chronic Care Management (CCM) program as well as the Collaborative Care Management program (CoCM) and am responsible for any co-payments that may apply. I understand I can be disenrolled from these programs at any time.

I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.

We appreciate you choosing us for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- I understand that I am responsible for co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations.
- I understand that if I have an insurance co-payment, I am expected to make payment within 30 days of billing or interest will begin to accrue on the unpaid balance.
- I understand that Seniority Healthcare may engage and collaborate with other specialists including but not limited to our Behavioral Health Team, for management of your health conditions.
- I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer group. Seniority Healthcare is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services.

I understand that I may review the Practice Privacy Notice as part of this registration process at any time upon my request. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Consent (Page 2 of 2)

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care. I have read and understand the Consents and Financial Policy stated above and agree to accept full responsibility as described above.

Patient/Legal Representative Name _____ **Date** _____

Patient/Legal Representative Signature

Medical Record Release Form

Patient Information

Patient Name	Date of Birth
_____	_____

The following section should be completed by a Seniority Healthcare Representative

Requested From

Name of Provider	Provider Contact
Address	

Send Information To

Name of Recipient	Recipient Contact
Address	

Information To Be Released

I hereby authorize Seniority Healthcare to request patient information on my behalf

Patient/Legal Representative Name _____

Patient/Legal Representative Signature