Kern Endocrine Center

Dear Patient,

The physicians of Kern Endocrine Center are now a division of Centric Health, a multi-specialty medical group. As part of this change, we have a new computer system and need some additional information from you. We appreciate your cooperation and patience during our transition. Please provide us with the following information. Thank you.

Primary Care Doctor: ______________________________

Patient Name: ______________________________ Date of Birth: ________________

Address: ______________________________ Zip Code: ________________

Social Security #: ______________________ Occupation: ____________________

Race: ____________ Preferred Language: __________ Marital Status: ______________

Main Phone #: __________________ Alt Phone # ______________________

May we leave a message? Yes or No

Would you like to enroll in our online patient portal?

- Yes, please provide email address: ____________________________
- No, please indicate reason: __Do not have an email __Prefer not to share __Other reason

Preferred Local Pharmacy: __________________ Phone #__________ Address__________________

Preferred Mail Order Pharmacy: __________________________ Phone # ___________________

PRESCRIPTION HISTORY CONSENT

I authorize the office of Kern Endocrine Center/Centric Health to access and use my electronic prescription history. I understand in doing so I am allowing Kern Endocrine Center/ Centric Health to access a full electronic history of prescriptions that have been prescribed to me by any/all of my healthcare providers. I acknowledge that I am allowing Kern Endocrine Center/Centric Health to access records in regards to prescriptions filled in my name by local, mail order and specialty pharmacies. This authorization will not expire unless a written request is received.

_________________________________ ________________________

Patient/ Responsible Party Signature Date

AUTHORIZATION TO TREAT

As a patient of Kern Endocrine Center/Centric Health, I consent to all medical care, examinations and test determined to be necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. If I refuse treatment that is suggested for me, or if I fail to complete any treatment protocol recommended to me, I will not hold the Kern Endocrine Center/ Centric Health or any individual responsible for any of the consequences.

_________________________________ ________________________

Patient/Responsible Party Signature Date