



Welcome to the practice. Please complete this packet before your first visit, or arrive 15 minutes early. You can type directly into this PDF, then print and sign the final page. We're glad you're here.

Patient Information

Legal last name Legal first name MI Preferred / chosen name

Date of birth (MM/DD/YYYY) Sex assigned at birth Gender identity Pronouns

Social Security # (optional) Marital status Preferred language Race/ethnicity (optional)

Contact & Address

Street address Apt / Unit

City State ZIP County

Cell phone Home / alt phone Email

Preferred contact method: ☐ Cell ☐ Email ☐ Home phone

Employment & Emergency Contact

Employer Occupation

Emergency contact name Relationship Phone



Primary Insurance

Insurance carrier

Member / ID #

Group #

Subscriber name (if not you)

Subscriber DOB

Relationship to subscriber

Secondary Insurance (if applicable)

Insurance carrier

Member / ID #

Group #

Preferred Pharmacy

Pharmacy name

Phone

Cross streets

Pharmacy address

A Few Quick Questions

Who may we thank for referring you? (doctor, friend, etc.)

How did you hear about us?

☐ Google search

☐ Friend / family

☐ Another provider

☐ Social media

☐ I would like Dr. Jones (or a provider here) to be my Primary Care Provider (PCP).



Reason for today's visit / main concern

Current medications & dosages (include supplements)

Allergies (medication, food, latex) & reaction

Have you ever been diagnosed with any of the following?

- | | | |
|--|---|---|
| ☐ High blood pressure | ☐ Diabetes | ☐ High cholesterol |
| ☐ Heart disease | ☐ Asthma / COPD | ☐ HIV |
| ☐ Hepatitis B / C | ☐ Thyroid disorder | ☐ Cancer |
| ☐ Kidney disease | ☐ Depression / anxiety | ☐ STI history |

Other conditions

Past surgeries & approximate year

Family history (parents/siblings — major conditions)

Social History

Tobacco use: ☐ Never ☐ Former ☐ Current

Alcohol: ☐ No ☐ Yes

freq/wk

Recreational / other substances: ☐ No ☐ Yes

details (optional, confidential)



Consent for Treatment

I voluntarily consent to medical care, examination, testing, and treatment provided by Anthony Jones, MD and the providers and staff of this practice, as deemed necessary or advisable. I understand that no guarantee has been made as to the results of any treatment or examination.

Financial Policy & Assignment of Benefits

I authorize my insurance benefits to be paid directly to the practice and accept financial responsibility for any balance not covered by my insurance, including copays, deductibles, coinsurance, and non-covered services. I authorize the release of medical information necessary to process insurance claims.

Notice of Privacy Practices (HIPAA)

I acknowledge that I have been offered, or have received, a copy of this practice's Notice of Privacy Practices, which describes how my protected health information may be used and disclosed.

Communication Authorization

We may contact me by: ☐ Voicemail ☐ Text ☐ Email ☐ Mail

People we may share your health information with (name & relationship)

Or write 'none'

By signing below, I confirm that the information I have provided is accurate and I agree to the statements above.

Patient / guardian name (print)

If guardian, relationship

Date

Signature

Date



Before Your First Visit

- ♥ Bring a photo ID and your insurance card(s).
- ♥ Bring a list of current medications, or the bottles themselves.
- ♥ Arrive 15 minutes early if you have not completed these forms in advance.
- ♥ Records from prior providers help us care for you — request them ahead of time if you can.
- ♥ Same-day appointments are available, and we see patients every Tuesday until 8:00 pm.

Office Hours

Monday	8:00 am – 5:00 pm
Tuesday	8:00 am – 8:00 pm
Wednesday	8:00 am – 5:00 pm
Thursday	8:00 am – 5:00 pm
Friday	8:00 am – 5:00 pm
Saturday & Sunday	Closed

Questions? We're here to help.

Call (510) 268-1800 · contact@anthonyjonesmd.com · 400 29th St #501, Oakland, CA 94609

An inclusive practice — every patient is welcome here, exactly as they are.