PATIENT UPDATE FORM 2024

PATIENT INFORMATION:

Name: ______________________________ ______________________________________ _______________
Last First Middle Initial

Sex: **M F** Date of Birth: _____ / ___ / _____ SS#: ______ / ______ / _________

Address: ________________________________
Street

________________________________ Home Phone: ___________________________

________________________________ Cell Phone: ___________________________
City , State, Zip code

Email Address: ____

Check one preferred method of automated reminder calls: ***please note, reminders are a courtesy not a guarantee***

____ 1) message on Home # ____ 2) message on Cell # ____ 3) text message on Cell #

INSURANCE INFORMATION:

Primary INS: ________________________________ Member ID#: ______________________________

* Policy Holder: _____________________________ Relationship to Patient: _______________________

Date of Birth: ______ / _______ / _________ Employer: ______________________________

Secondary INS: ______________________________ Member ID#: _______________________________

I have provided a copy of the front and back of my insurance card **Initial Here:** __________

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Individuals that I approve to share information with:

____ _________________________ ____________________
Name Relationship to patient Phone #

____ _________________________ ____________________
Name Relationship to patient Phone #

Primary Care Physician _____________________________ May we communicate with PCP (check one)? __YES __ NO

Credit Card information to be on file: (Required for telehealth and/or early and late appointments)

Name as appears on card: ____

_________ _________ _________ _________ Expiration _____ / ______ Security Code ________

** I am aware that should I **cancel under 24 hours** prior to an appointment, and/or No show for my appointment, there is a $75 fee that is *my responsibility* and is not billable to my insurance.

Initial Here: __________

** Should I request **medication refills** in between appointments, I understand there is a $30 fee for this service.

Initial Here: __________

I AUTHORIZE & ACCEPT RESPONSIBILITY FOR PAYMENT ON THIS ACCOUNT

X____ Date: ____________________________
Patient or Responsible Party Signature