PATIENT UPDATE FORM 2026 Date: _____

**Patient Name:** _____ _____ _____
Last First Middle Initial

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

**Address:**

_____ Home Phone: _____
Street

_____ 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: _____ / _____ / _____

Secondary INS: _____ Member ID#: _____

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

**********

**Approved individuals to share information with:** *NAME MUST BE WRITTEN BELOW OR PREV. INDIVIDUALS WILL BE REMOVED*

1) Name _____ Relationship to patient _____

2) Name _____ Relationship to patient _____

Primary Care Physician _____ May we communicate with PCP? __YES __NO

**********

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

Name on card: _____

Card # _____ _____ _____ _____ Expiration _____ / ____ Security Code _____

**********

* I am aware that if I **cancel under 24** hours prior to an appointment, there is a minimum **fee of $75.**

Initial Here: _____

* If I **No Show** for an appointment –

**1st No Show - $75,**
**2nd No Show - $200,**
**3rd No Show - I will be asked to transfer my records to another practice.**

Initial Here: _____

*Should I request **Medication Refills** in between appointments, I understand there is a **$30 fee.** **(Med Management Patients only)**

Initial Here: _____

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I Authorize and Accept Responsibility for Payment on this Account:

Patient or Responsible Party Signature X _____