PATIENT UPDATE FORM FOR 2021

Please Print Clearly

Date: ________________________

Name: ___________________________ ___________________________________ ______________
Last First Middle Initial

Address: ______________________________ Sex: **M F**

____________________________________ Date of Birth: _____ / _____ / _____

____________________________________ SS#: ______ / ____ / ______

Check one preferred method of automated reminder calls:
please note, reminders are not guaranteed

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

Home Phone: _________________________ Cell Phone: _________________________

Email Address: ____

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:** __________

Individuals that I approve to share information with:

Name	Relationship to patient	Phone #

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

Credit Card information to be on file: 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 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 $20 fee for this service.

  Initial Here: __________

I AUTHORIZE & ACCEPT RESPONSIBILITY FOR PAYMENT ON THIS ACCOUNT

X____
Patient or Responsible Party Signature