2023 PATIENT UPDATE FORM

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