

PATIENT UPDATE FORM FOR 2022

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:

<u>Name</u>	<u>Relationship to patient</u>	<u>Phone #</u>
_____	_____	_____
_____	_____	_____

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