PATIENT UPDATE FORM 2025 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:

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 offense - $75,
2nd offense - $200,
3rd offense - 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.**

Initial Here: _____

****

I Authorize and Accept Responsibility FOR Payment on this Account:

X _____
Patient or Responsible Party Signature