

Annual Patient Information Update Form

Name: _____ DOB: _____

Address: _____

Email Address: _____ Cell Phone#: _____ Home Phone#: _____

Insurance Co. Name: _____ Ins. Co. Provider Phone#: _____

Patient ID#: _____ Effective Date: _____

I confirm that all the information above is accurate and has been personally confirmed by me. _____, initials

pt, Signature _____ Date: _____

PLEASE SUBMIT THIS FORM ALONG WITH YOUR CURRENT & ACTIVE INSURANCE CARD

PLEASE READ, UNDERSTAND AND CONSENT TO THE FOLLOWING, (WE ARE HAPPY TO ANSWER ANY AND ALL QUESTIONS YOU MAY HAVE). THANK YOU

1. Please obtain ALL refills you need from the doctor while you are in the office. Except in emergencies, refills are handed to patients or for controlled meds, called in directly to the pharmacy at time of service.
2. Ensure that you have set up your patient portal. This is important as all lab results, statements etc. are sent to the portal.
3. Any and all outstanding balances must be paid off at the time of service.
4. There is a fee for all forms and any other papers the doctor must sign or complete for patients. Please allow at least a 7-day turnaround for such forms.