



Established Patient Update Form

Patient Information:

Last Name: _____ First Name: _____ Today's Date: _____

Other/Maiden Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Cell Phone: _____ Other Phone: _____

Email: _____

(By providing your email, you will be receiving communications regarding our patient portal and care center services)

What is your preferred method of communication (Mark all that apply):

Cell Phone – Text Cell Phone – Voice Other Phone Email

Is it okay to leave a brief message with medical information and/or appointment reminders to your preferred method of communication? Yes No

Marital Status: Single Married Widowed Divorced Separated Domestic Partner

Spouse/Domestic Partner Name: _____

Employment Information

Employment/Student Status: Full-Time Part-Time Not Employed Self-Employed Active Military
 Retired Full-Time Student Part-Time Student

Employer: _____

Occupation: _____ Phone: _____

Minor Information (under 18 and not emancipated)

Parent/Legal Guardian Name: _____ Phone: _____

Relationship: Parent Grandparent Other Relative Other _____

Emergency Contact

Name: _____ Phone: _____

Relationship: Spouse/Partner Parent Child Other Relative Friend Other

Primary Care Provider/Referring Provider

Primary Care Physician: _____ Phone: _____

Address: _____

Referring Physician (if different): _____ Phone: _____

Address: _____

Pharmacy Information

Local Pharmacy Name: _____ Phone: _____

Address: _____ City, State, Zip: _____

Mail In Pharmacy Name: _____

Insurance Information

Primary Insurance Provider: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Employer: _____

Secondary Insurance Provider: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Employer: _____

Friends and Family involved in care (Optional)

I give permission for the following individuals to receive information about my treatment and payment to assist in my healthcare. I understand this permission is valid until revoked.

Same as my emergency contact listed above

Name: _____ Phone: _____

Relationship: Spouse/Partner Parent Child Other Relative Friend Other

Name: _____ Phone: _____

Relationship: Spouse/Partner Parent Child Other Relative Friend Other

By signing below, I acknowledge I have read, understand, and agree to the above regarding Authorization for Treatment, Payment and Healthcare operations.

Patient/Authorized Signature

Date

Patient Name: _____

DOB: _____