DEMOGRAPHIC UPDATE

Patient Information:

Patient's Name: _____

DOB: _____Age: _____ Sex: (F) (M)

Mailing Address: _____

City, State, Zip

Home #: _____ Work #: _____ Cell #: _____

Marital Status: (M) (S) (D) (W) Spouse's Name: _____

Email address _____

Insurance Information:

Primary insurance: _____ Phone #: _____

Policy #: _____ Group #: _____

Subscriber's name: _____ Relationship to patient: _____

Subscriber's DOB: _____ Subscriber's SSN: _____

Secondary insurance: _____ Phone #: _____

Policy #: _____ Group #: _____

Subscriber's name: _____ Relationship to patient: _____

Subscriber's DOB: _____ Subscriber's SSN: _____

MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

Name: _____ Date of Birth:____/____/_____

RELEASE OF INFORMATION

( ) I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

( ) Spouse_____

( ) Child(ren)_____

( ) Other_____

( ) Information is not to be released to anyone

This release of information will remain in effect until terminated by me in writing.

MESSAGES

Please call ( ) my home ( ) my work ( ) my cell number;_____
If unable to reach me:

( ) you may leave a detailed message
( ) you leave a message asking me to return your call
( ) _____

The best time to reach me is (day)_____between (time)_____

Signed_____ Date ___/___/_____

Witness _____ Date ___/___/_____