DEMOGRAPHIC UPDATE

Patient Information:

Patient'sName:____

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 ___/___/________