ANNUAL UPDATE OF PATIENT INFORMATION

PATIENTS INFORMATION

LAST NAME__________________________ FIRST__________________________MI____________
ADDRESS__________________________________ CITY__________________STATE____________
ZIP CODE________________HOME PHONE________________________________
WORK PHONE________________________ CELL PHONE________________________

EMPLOYERS NAME____
ADDRESS____
CITY,STATE,ZIP____

NAME OF A PERSON NOT LIVING WITH YOU WE MAY CONTACT IN CASE OF AN EMERGENCY____

INSURANCES INFORMATION

PRIMARY INSURANCE

NAME OF COMPANY_______________________ MEMBER #/ID#____________________________
POLICY HOLDERS NAME____

SECONDARY INSURANCE

NAME OF COMPANY______________________ MEMBER#/ID#_____________________________
POLICY HOLDERS NAME____

AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf.

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SIGNATURE OF PATIENT/PARENT OF MINOR DATE