CONFIDENTIAL

INFORMATION UPDATE

Date _____

SS/HIC/Patient ID# _____ Date of Birth _____

Patient Name _____
Last Name First Name Middle Initial

Address _____
Street City State Zip

E-mail _____ Sex ☐ M ☐ F Age _____ Minor ☐

Home Phone (___) _____ Cell Phone (___) _____ Work Phone (___) _____ Ext ____

Any changes to your insurance or employer? Please note here. _____

_____

_____

Any changes to your health? Please note here. _____

_____

_____

New Allergies _____

Recent Hospitalizations _____

List Current Medications _____

_____

_____

Women: Are you pregnant? ☐ Yes ☐ No

☑ Insurance Assignment and Release

I certify that I (and/or my dependent(s)) have insurance coverage with _____
Name of Insurance Company (ies)

_____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

☑ Medicare/Medigap Authorization

Medicare No. _____

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to: _____ for any services furnished to me by that provider.
Name of Doctor, Clinic, Healthcare Provider or Supplier

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____
Signature of Beneficiary, Guardian, or Personal Representative Date

_____ _____
Please print name of Beneficiary, Guardian, or Personal Representative Relationship to Beneficiary