GENERAL PATIENT UPDATE

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PLEASE PRINT CLEARLY

PATIENT INFORMATION

NAME: _____
LEGAL: FIRST NAME | MIDDLE NAME | LAST NAME | PREFERRED NAME

MAILING ADDRESS: _____
ADDRESS | CITY | STATE | ZIP

May we send a statement or receipt to this address? ____ ***YES*** ____ ***NO***

STREET ADDRESS IF DIFFERENT: _____

TELEPHONE: (____) _____ (____) _____
CIRCLE ONE: LANDLINE OR CELL PHONE — CIRCLE ONE: LANDLINE OR CELL PHONE

May we contact you by phone? ____ ***YES*** ____ ***NO***

DATE OF BIRTH: _____ **SEX:** ____ MALE ____ FEMALE

MARTIAL STATUS: ____ SINGLE ____ MARRIED ____ SEPARATED ____ DIVORCED ____ WIDOWED ____ LIFE PARTNER
____ DOMESTIC PARTNER ____ OTHER _____

RACE: ____ WHITE ____ ASIAN
____ BLACK OR AFRICAN AMERICAN ____ NATIVE ALASKAN
____ AMERICAN INDIAN ____ NATIVE HAWAIIAN
____ OTHER _____

ETHNICITY: ____ HISPANIC / LATINO ____ NON HISPANIC / LATINO

PREFERRED LANGUAGE: _____ **COUNTRY OF ORIGIN:** _____

ARE YOU A VETERAN? ____ YES ____ NO **IF YES, WAR OR CONFLICT SERVED IN:** _____

EMERGENCY CONTACT: _____ (____) _____
NAME | RELATIONSHIP | TELEPHONE NUMBER

EMPLOYMENT

NAME OF EMPLOYER: _____ TELEPHONE NUMBER (____) _____

INSURANCE / PHYSICIAN

DO YOU HAVE INSURANCE : ____ YES ____ NO **CHECK ONE:** ____ PRIVATE INSURANCE ____ MEDICAID ____ MEDICARE/ ADVANTAGE PLAN

INSURANCE COMPANY: _____ **POLICY #:** _____

NAME OF POLICY HOLDER: _____ **DATE OF BIRTH:** _____

WHAT IS YOUR RELATIONSHIP TO THE INSURED? ____ SELF ____ SPOUSE ____ CHILD ____ OTHER

PRIMARY CARE PHYSICIAN: _____

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

_____ _____
SIGNATURE OF PATIENT OR PARENT / GUARDIAN | DATE

FOR OFFICE USE ONLY:		HIPAA		CONSENTS		BILL RESPONSIBILITY or DECLARATION OF INCOME	UPDATED:		PATAGONIA		FLAGS		NCIR