WHAT'S NEW

1 About You

Patient Name: ______________________________

Mailing Address: ______________________________

(☐ no change)

____

CITY STATE ZIP

Best Contact Number: ______________________________

Email Address: ______________________________

I would like to receive

☐ Email ☐ Text ☐ No

For the following

- ☐ Appointment reminders/Recall Visits
- ☐ Information regarding billing/insurance
- ☐ Requests for Patient Satisfaction reviews

2 Insurance Info

Has any of your insurance information changed? ☐ Yes ☐ No

If your insurance info has **not** changed, please continue on to block 3.

Company Name: ______________________________

Address: ______________________________

____

CITY STATE ZIP

Phone Number: ______________________________

Insured ID: ______________________________

Group #: ______________________________

Insured Name: ______________________________

Relationship: ____________________ Date of Birth: __________

Insured Employer: ______________________________

____________ *Initials* I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Please provide any **new** Primary/Secondary Ins cards with this form.

3 Medical Information

What medications are you taking? (please include over-the-counter drugs) ______________________________

____

Please list any **new** allergies, diseases, medical conditions or procedures; include dates when possible: ______________

____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any further changes to the information I have provided.

Signature ______________________________ Date ______________