PATIENT INFORMATION UPDATE

(Form needs to be filled out entirely)

PATIENT NAME: _____ **DOB:** _____

MARITAL STATUS: *SINGLE / MARRIED / DIVORCE / SEPERATED / WIDOWED*

ADDRESS: _____
STREET *CITY* *STATE* *ZIP CODE*

HOME PHONE: _____ **CELLPHONE:** _____

EMAIL: _____

EMPLOYER/SCHOOL: _____ **PHONE#:** _____

EMERGENCY CONTACT: _____ **RELATIONSHIP TO PATIENT:** _____

HOME PHONE: _____ **CELLPHONE:** _____

PREFERRED PHARMACY: _____

PHARMACY ADDRESS: _____

PHARMACY PHONE: _____

Has your insurance changed in any way? Yes No
(If your insurance has not changed, you do NOT need to fill out the next section)

PRIMARY INSURANCE: _____

MEMBER ID: _____ **GROUP #:** _____

POLICY HOLDER: _____ **POLICY HOLDER DOB:** _____

SECONDARY INSURANCE: _____

MEMBER ID: _____ **GROUP #:** _____

POLICY HOLDER: _____ **POLICY HOLDER DOB:** _____

RELEASE OF MEDICAL INFORMATION

I, the patient, hereby authorize Lee Family Practice to release limited medical information (appointment info, lab/radiology results, diagnoses, treatments, medications, surgeries, etc.) via mail, telephone or fax to the following family members:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If you are expecting changes in your address or phone numbers, please remember to notify us so that we may update your information in our records