



Patient Update Form

Today's Date _____

Patient Name _____

Mailing Address _____ City _____ State _____ Zip _____

Telephone Home _____ Work _____ Cell _____

(As a service to our clients, we provide a courtesy appointment reminder call that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.)

Social Security _____ Date of Birth _____

Marital Status: Single Married Divorced Widowed

Employer _____ Telephone _____

Authorized Parties to Speak with Regarding your Billing: _____

Insurance Information:

Primary Insurance _____

Name of Subscriber _____ Date of Birth _____ Social Security _____

Secondary Insurance _____

Name of Subscriber _____ Date of Birth _____ Social Security _____

Emergency Contact Information:

Name _____ Relationship _____ Telephone _____

I hereby authorize medical treatment of the above named patient and agree to be financially responsible for all charges for such treatment, including costs of collection and legal fees (if applicable). I hereby assign payments to Internal Medicine Group. I authorize Internal Medicine Group to release any medical information necessary to process my insurance claims. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

Patient /Parent/ Guardian Signature _____ **Date** _____