

PATIENT REGISTRATION UPDATE

Name _____

Please Fill in Only the Section Which Pertains to the Change

Address _____
(Street) (City) (State) (ZIP)

Phone H _____ W _____ Marital Status M ____ S ____ D ____ W ____

Insurance: Please indicate if change is in Primary _____
Secondary _____

New subscriber number _____ New group number _____

New insurance company name _____

Address _____

Phone _____

Employer _____ Phone _____

PLEASE SIGN THE FORM BELOW TO UPDATE OUR RECORDS

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR TREATMENTS: I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf or to myself. I understand that I am financially responsible for all charges not covered by my insurance.

Patient or Authorized Representative

Date