

DEMOGRAPHIC CHANGE

Name _____
(First) (M.I.) (Last)

Address _____
(Mailing Address-Street or P.O. Box)

(City) (State) (Zip Code)

Phone _____
(Home) (Work) (Cell)

INSURANCE CHANGE:

NEW INSURANCE: _____

I.D.# _____ GROUP# _____

INSURED NAME: _____ DOB: _____

USE & DISCLOSURE INFORMATION:

You may leave messages on answering machine for the following (please initial):
____ Referrals ____ Prescriptions ____ Test Results ____ Other: _____

You may discuss my treatment and care with the following individuals:

Do you have a Living Will (Advanced Directive) or a DNR (Do not resuscitate) ____ YES ____ NO.

NO-SHOW ACKNOWLEDGEMENT

I understand the importance of keeping my scheduled appointment and agree to notify the office at least 24 hours in advance, if I am unable to keep my appointment. I also understand that if I do not give the required notice, I will be charged a fee of \$25.00.

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to whatever evaluation or treatment the assigned physician may deem necessary to the patient name above.

Signature _____ **Date** _____