Patient Update Form

PATIENT'S NAME(Last, MI,First):
Has your address change?
New Address:

Has your Insurance info change?
If so, complete below:

New Insurance Company Name:
ID Number: Group Number:
Insured's Name: Insured's DOB:
Insured's Employer:

Do you have a secondary Insurance :
If so, complete below:

Secondary Insurance Company Name
ID Number: Group Number:
Insured's Name: Insured's DOB:
Insured's Employer:
PHARMACY PHONE NUMBER AND ADDRESS:

Email update:

PATIENT'S DOB: **AGE:**
Home Telephone:
Cell Phone:

Race and Ethnicity question now required by CCHIT/CMS. Please circle below:

White, Black of African American, Asian, Hispanic or Latino; American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Some other Race, Decline to disclose.

Mother's Name:
Mother's Employer:
Father's Name:
Father's Emploer:

CLINIC USE ONLY:
TVFC Eligible:

[ ] Yes or [ ] No

Main Reason for Today Visit:
[ ] SICK VISIT [ ] WELL VISIT:
Problem(s)

Immunization up to date?
Is your child's growth and development normal? If NOT explain your concerns:

Medication Taken: [ ] None at all [ ] Listed below:

Any health changes: [ ] No medical Condition:
SURGERIES?
HOSPITALIZATION/ ER VISITS?
ALLERGIES TO MEDICATION, FOOD OR LATEX:

Authorization/Financial Responsibility/Privacy Policy

I acknowledge that I have finacial responsibility for payment of all services rendered even if I have health insurance. I am responsible for any charges. I accept resposibility for all cost incurred in my treatment. I authorize the release of any medical or other information necessary to process claims or bills. I also request payment of government benefits or commerical insurance to the paty that accepts assignment. I authorize payment of medical benefits to Linda Neely M.D. and or Good Health Pedicatrics & Wellness Clinic, LLC for services done.

PRIVACY POLICY: The most common reason why we use or disclose your health information is for treatment, payment, or health care operation. We may call or write to remind you of sheduled appointment or write to notify you of other treatment or "authorized form". The contserces available at out office. We will not make any other uses or disclosures of your health information unless you have sign a written ent of an "authorization form" is determine by federal law. I understand I may request to read the full text of our privacy policy at the time. I acknowledge that I have received notice of Good Health Pediatrics & Wellness Clinic, LLC Privacy Practices.

By signing this form, I am consenting to medical evaluation and office procedures and treatment and agreeing to office policies. I understand this authorization will remain in effect until I revoke it in writing.

Signature of Patient/Responsible Party Relationship to Patient Date