The Oaks
Family Healthcare LLC

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Patient Update Form

Today's Date: _____

Please complete the below information, to the best of your knowledge.

NAME: _____ **BIRTHDATE** _____

ADDRESS: _____

PHONE: *HOME* ( ) _____ *WORK*: ( ) _____ *CELL*: ( ) _____

EMAIL ADDRESS: _____ **SSN:** _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

PHARMACY NAME/ADDRESS/PHONE: _____

INSURANCE COVERAGE—PRIMARY

Name of Insurance: _____

Contract/Policy #: _____ Group Name: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder's DOB: _____

Relationship to Policy Holder: _____

INSURANCE COVERAGE—SECONDARY

Name of Insurance: _____

Contract/Policy #: _____ Group Name: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder's DOB: _____

Relationship to Policy Holder: _____

Authorization to Release Information:

I authorize the release of medical information and records concerning my treatment to Medicare, Medigap, and/or other insurance companies and assign my claim for medical benefits to the Practice to the extent permitted under applicable law or insurance agreements. I agree to allow the Practice to request and release my medical records from the other physicians or medical institutions as it deems necessary for my medical care and I further authorize the release of my medical records by such parties for such purpose. I agree to allow the Practice to use my medical information and photography in an anonymous manner for the purpose of teaching or publication. I release the Practice from all legal responsibility or liability that may arise from above authorizations and agreements.

Appointment Reminder Policy:

I authorize this Practice and their agent to place appointment reminder phone calls or text messages to the phone I have listed on my patient form.

Consent to Treatment:

I authorize the physicians of the Practice, their associates, technical assistants, and other health care providers under their direction to provide diagnostic evaluation and treatment. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination and/or treatment.

_____ _____

PATIENT OR PARENT/GUARDIAN SIGNATURE **DATE**