Silver Sage Center for Family Medicine

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PATIENT INFORMATION UPDATE SHEET

Name ____
Last First MI Date of Birth

Physical Address____
Address City State Zip

Mailing Address____
Address City State Zip

Patient Phone______________________ Cell_________________________ Work _______________________

E-Mail____ Sex: M F Marital Status: S M D W

Social Security _____________________________ Race:________________

If Minor, Parent Name: ____

Emergency Contact: ____
Name Phone Relationship

Preferred Pharmacy & Location: _______________________________

What is the best means to contact you: (Please circle one) E-mail Home phone Cell phone or Mail?

I understand that co-payments are due at the time of visit. I authorize payment of medical benefits from my insurance company to Silver Sage Center for Family Medicine. I also authorize the release of any medical information necessary to process any medical claim. **We bill insurance as a courtesy to you**. **You realize that you are responsible for any balance accrued at the time of visit should your insurance company not cover/pay. You acknowledge receipt of the privacy policies and practices notice (paper copy available by request).**

Signature: ____ Date:______________________

Is there a friend or family member(s) that we may disclose your medical information with? Name and relation:

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We do not discriminate against anyone regardless for color, race, creed or physical ability.