Registration Update Form

[ ] New Patient [ ] Est. Pt. (Update form)

ADPC Provider: Acct: Date:

Last Name:	First Name:	MI:	SS#:

Address:

City:TUCSON	State:	ZIP:

Home Phone:	Work Phone:	Cell Phone:

Sex:	DOB:	Age:

Employer Name:

Referring Doctor:	Primary Care Physician:

Marital Status:	Employment Status: FT PT N/A	Student Status: FT PT N/A

INSURANCE INFORMATION:

Primary Ins:	Policy #:	Group#:
Policy Holder:	Policy Holder DOB:	Policy Holder SS#:

2ndary Ins:	Policy #:	Group#:
Policy Holder:	Policy Holder DOB:	Policy Holder SS#:

For Winter Visitors:

Alternate Address: _____

Months you reside in AZ:_____

Authorization for release of medical information, benefit assignment, & payment of account

I authorize ADPC to release medical information for insruance purposes concerning treatment of the above named patient while under their care. I authorize payment of any Insurance Benefits for medical or surgical services directly to ADPC. I agree to pay any fees not covered by Insurance Benefits direclty to ADPC. If collection proceedings are required, I agree to pay all reasonable collection fees. If insurance does not pay within 30 days for any reason I understand that I am responsible for the balance. If Pathology is required I understand I will receive a seperate bill from the Pathologist.

Also, I have reviewed my information and confirm that it is correct. If not, I have made the appropriate changes.

Signed: (Patient or Parent, if minor) _____ Date: _____

For Office Use Only

Acct No: _____ Dr #: _____ [ ] NP [ ] Update HIPPA Update: _____ Employee:_____