# Registration Update Form

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

ADPC Provider: Acct: Date:

| Last Name: | First Name: | MI: | SS#: |
|---|---|---|---|

| Address: |
|---|

| City: | State: | ZIP: |
|---|---|---|

| Home Phone: | Work Phone: | Cell Phone: |
|---|---|---|

| Sex: | DOB: | Age: |
|---|---|---|

**Preferred Contact Method:**
[ ] Patient Portal (Email: ) [ ] Phone [ ] Letter

| **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 #: |
|---|---|---|
| Policyholder: | Policyholder DOB: | Policyholder SS#: |

| 2ndary Ins. | Policy #: | Group #: |
|---|---|---|
| Policyholder: | Policyholder DOB: | Policyholder SS#: |

**EMERGENCY CONTACT:** _____ Phone #: _____ Relation: _____

**I authorize the practice to release medical information and/or results for TODAY'S visit to the following family member(s):**

Name _____ Relation: _____ Date: _____

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

I authorize ADPC to release medical information for insurance 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 directly 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 separate bill from the Pathologist. **Effective 1/1/2019 there will be a $25 fee for "no show" appts. and appts. cancelled with less than 24 hours notice (Mon. appts. need to be cancelled by noon the previous Friday).**

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 _____