

# Patient Update Information Form

Dear Patient:

Please take a moment to complete our new, and simple-to-complete patient information form. If you need any help in completing this form, do not hesitate to ask our front desk staff for help. We realize that some patients suffer from arthritis and other conditions making it difficult to write.

**After you have finished completing this, please bring it up to the front desk along with a copy of your current insurance card.**

Name: \_\_\_\_\_  
Last Name First Middle Initial

Address \_\_\_\_\_  
Street Number and Name Apt. #

\_\_\_\_\_ City State Zip

Day Phone #:

\_\_\_\_\_ Area Code Number Extension

Evening Phone #:

\_\_\_\_\_ Area Code Number Extension

***Name of Person to contact in case of emergency:***

\_\_\_\_\_ Last Name First Relationship

Phone # of above:

\_\_\_\_\_ Area Code Number Extension

## **Insurance Information Change**

Company Name: \_\_\_\_\_

Claims Filing Address: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Telephone Number for Insurance Company: \_\_\_\_\_

***If your marital status has not changed you can skip this section:***

Name of Spouse:

\_\_\_\_\_ Last Name First Middle Initial

Spouse Date of Birth:

\_\_\_\_\_ Date Month Year

***All patients must sign and date:***

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

*Please obtain a new copy of the Insurance card, Front and Back*

Patient Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Medication Allergies? \_\_\_\_\_

**List of Current Medications (OTC and Prescription) Reason of Medication**


**Medical Conditions Know to the Patient:**

1.
2.
3.

**Have you ever been hospitalized? If Yes, please list dates and problems**

Year	Problem / Surgery	Hospital	Physician

Do you have a History of:	Yes	No
Asthma		
Dermatitis		
Eczema		
Hepatitis C		
Herpes		
HIV / AIDS		
Hyperthyroid		
Hypothyroid		
Liver Disease		
Lupus		
Melanoma		
Murmur		
Psoriasis		
Skin Cancer		
Tinea (skin/foot fungus)		
Warts		

Do you have:	Yes	No
Adhesive Allergy		
Advanced Directive (Health Care Proxy)		
Bowel or Urination Changes		
Changing moles (color, size, bleeding)		
Chills		
Cough		
Depression		
Difficulty Sleeping		
Difficulty Hearing		
Fevers		
Hair loss or nail changes		
Headaches		
Immunizations up to date?		
Latex Allergies		
Muscle or joint aches		
Recent Stress		
Sensitive skin		
Unexplained weight gain or loss		
Vision Problems		

Does Anyone in Your Family have a History of:	Yes	No
Allergies		
Asthma		
Cancer		
Cancer of the Skin		
Dermatitis		
Eczema		
Melanoma		
Psoriasis		

Provider Reviewed: \_\_\_\_\_

Date: \_\_\_\_\_

***Personal Habits*****Alcohol** (amount per day / week) \_\_\_\_\_**Coffee, Cola** (amount per day) \_\_\_\_\_**Laundry Detergent Brand** \_\_\_\_\_**Dryer Sheets?** \_\_\_\_\_**Pets (what kind?)** \_\_\_\_\_**Soap (brand)** \_\_\_\_\_**Suntan Parlors (frequency)** \_\_\_\_\_**Smoking (amount per day, how many years)** \_\_\_\_\_