Advantage Plus Medical Center
Family, Occupational and Addiction Medicine

Patient Information Update Sheet

Please completely fill out all areas that apply to ensure that we have your correct information in our system.

PATIENT INFORMATION

Name____

Date of Birth__________________________ Social Security No._______________________________

New Address____

Street Address City State Zip Code

Primary Phone Number____ ☐ Cell ☐ Home ☐ Work

Secondary Phone number ____ ☐ Cell ☐ Home ☐ Work

E-mail Address______________________ Language ☐ English ☐ Spanish ☐Arabic ☐ Other__________

PHARMACY INFORMATION

Pharmacy Name ____________________________ Phone Number ______________________________

Fax Number ________________________________

Address____

Street Address City State Zip Code

EMERGENCY CONTACT

Contact Name ______________________________ Relationship ______________________________

Contact number ______________________________

INSURANCE INFORMATION

(Please present your new Health Insurance card to the front desk staff if it has been changed)

Primary Insurance: __________________________ Address: ___________________________________

ID #: _____________________________________ Group: _____________________________________

Name of Primary Subscriber: __________________ Subscriber DOB: _______________

My signature below authorizes (a) the release of any medical or other information necessary to process insurance claims, and (b) payment of medical benefits directly to this practice for services rendered.

____ ______________________________

Patient Name (Please Print) Patient Signature

____ ______________________________

Name of authorized person, if different from Patient Today's Date

Please present your current insurance card whenever you or a dependent check-in for an appointment and notify us of any changes in your insurance as soon as possible.

Thank you