MI-WI FAMILY PRACTICE ASSOCIATES, P.C.

1711 S. Stephenson Avenue, Suite 300 IRON MOUNTAIN, MI 49801 (906) 774-1633

PATIENT UPDATE FORM

PATIENT NAME:_____ DATE OF BIRTH:_____/_____/_____AGE:_____
(LAST) (FIRST) (MI)

ADDRESS: _____ SEX:_____ Marital Status_____

_____ SS#:_____ _____ _____

_____ EMPLOYER: _____
CITY STATE ZIP

PHONE: ( ) _____ WORK PHONE: _____

SPOUSE OR PARENT NAME:_____ OCCUPATION: _____

INSURANCE INFORMATION

INSURANCE POLICY HOLDER INFORMATION

POLICY HOLDER SS#:_____

1ST INSURANCE CO.:_____

POLICY #:_____

GROUP #:_____

(POLICY HOLDER)

RESPONSIBLE PARTY:_____

DATE OF BIRTH:_____

ADDRESS OF INSURANCE: _____

_____

PHONE:_____

RELATIONSHIP TO PATIENT:_____

POLICY HOLDER EMPLOYER: _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE #:_____

INSURANCE POLICY HOLDER INFORMATION

POLICY HOLDER SS#:_____

2ND INSURANCE CO.: _____

POLICY #:_____

GROUP #:_____

(POLICY HOLDER)

RESPONSIBLE PARTY:_____

DATE OF BIRTH:_____

ADDRESS OF INSURANCE: _____

_____

PHONE:_____

RELATIONSHIP TO PATIENT:_____

POLICY HOLDER EMPLOYER: _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE #:_____

PERSON TO NOTIFY IN CASE OF EMERGENCY:_____RELATIONSHIP_____

PHONE: _____

I AUTHORIZE RELEASE OF ANY INFORMATION REQUIRED TO PROCESS CLAIMS SUBMITTED TO MY INSURANCE CARRIER AND PERMIT PHOTOGRAPHIC OR OTHER FACSIMILE OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I HEREBY ASSIGN TO DR. MITCHELL, ANY MEDICAL AND/OR SURGICAL BENEFITS TO WHICH I OR MY INSURED DEPENDENTS ARE ENTITLED AS A RESULT OF CLAIMS FILED WITH MY INSURANCE. I UNDERSTAND THIS ORDER DOES NOT RELIEVE ME OF MY OBLIGATION TO PAY ANY INELIGIBLE OR DISPUTED AMOUNTS OR ANY BALANCE DUE AFTER INSURANCE PAYMENTS. I UNDERSTAND THAT I HAVE THE PRIMARY DUTY AND OBLIGATION TO PAY MY DOCTOR FOR SERVICES, NOTWITHSTANDING ANY CONTRACT THAT I MAY HAVE WITH A THIRD PARTY (BE IT INSURANCE COMPANY, EMPLOYER, UNION, OR THE LIKE).

The undersigned recognizes that a condition exists requiring treatment(s) and do hereby voluntarily consent to such care, diagnostic procedure and medical treatment.

Signature_____Date _____Date _____Date_____

Medical Authorization: Patients certification, authorization to release information, and payment release. I certify that the information given by me to applying for payment under title XVI of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediate or carriers any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician service to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to medicare for payment to me.

Signature_____Date _____Date _____Date_____

PLEASE GIVE TO RECEPTIONIST WITH INSURANCE CARDS. THANK YOU.

CJ #131105