Visalia Ob/Gyn Medical Associates, Inc
Patient Demographic Update Form

Account #:	**PATIENT INFORMATION**				
Last Name:			SSN#:		
First Name:		Mid. Initial:	DOB:		Sex:
Home Address1:			Age:		
Apt/Suite #:			Cell Tel#:		
City, State, Zip:			Home Tel#:		
Email:			Work Tel#:		
Race:		Ethnicity:		Language:	
HOW DO YOU PREFER YOUR APPOINTMENT REMINDER (please check boxes below)					
Preferred Phone Method:	Home ☐ Work ☐ Cell ☐		Communicate by:	Phone ☐ Email ☐ Text ☐	
PREFERRED PHARMACY					
Pharmacy Name:			Pharmacy Tel#:		
Pharmacy Address:			City/St/Zip:		
EMPLOYER INFORMATION					
Name:			Phone#:		
Address:			Suite #:		
City/St/Zip:					
EMGERGENCY CONTACT INFORMATION: (In case of emergency who should be notified?)					
Name:		Tel#		Relationship:	
PRIMARY INSURANCE					
Plan/Policy Name:			Group #:		
Plan Tel#:			Subscriber DOB:		
Subscriber Name:			Subscriber ID:		
Relationship to Patient: (check box)	☐ Self	☐ Wife	☐ Husband	☐ Parent	☐ Other
SECONDARY INSURANCE					
Plan/Policy Name:			Group #:		
Plan Tel#:			Subscriber DOB:		
Subscriber Name:			Subscriber ID:		
Relationship to Patient: (check box)	☐ Self	☐ Wife	☐ Husband	☐ Parent	☐ Other

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT
I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements promptly upon presentment thereof, unless credit arrangements are agreed upon. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper.
It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims there on, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.)
NOTICE: Do not sign this agreement before you read and agree to the conditions set forth on the reverse side. You are entitled to a copy of the agreement at the time you sign in. Keep it to protect your legal rights.
AGREEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification. I authorize Visalia Ob/Gyn medical associates to furnish information to insurance carriers concerning my illness and treatments, and hereby acknowledge receipt of a copy of this form.
I hereby acknowledge that i have been offered a copy of this medical practice's notice of privacy practices.

Patient or authorized person's signature: ______________________ **Date:** ____________