ANNUAL UPDATE FORM

1a. **Patient Name** ____

Last Name **First Name** **Middle**

Date of Birth:_______________________________________ **Age**______________________________

1b. **If a minor**

__________________________ ________________________________

Mother's name/Legal Guardian *Father's name/Legal Guardian*

2. **Sex:** ( ) Male ( ) Female ( ) U

Gender ( )Male ( ) Female ( ) Transgender Male ( ) Transgender Female ( ) Other ( ) Refuse to Report

Sexual Orientation: ( ) Lesbian, gay or homosexual ( )Straight or heterosexual ( ) Bisexual

( ) Something else (please specify)______________________ ( ) Unknown ( ) Refuse to Report

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated ( ) Life Partner

( ) Legally Separated ( ) Unknown

3. **Mailing Address** ____ Apt. _________________

City _____________________________State _______ Zip Code ________ County_________________

Phone # Home __________________ Cell ____________ Best way to reach you? □Home □Cell

4. **Emergency Contact Phone#:** ____

Relationship to Patient:____

5. **Housing** □ Public Housing □Homeless Shelter □Doubling Up □Other □ Street □Transitional □Unknown

6. **Agricultural** □ Dependent of Migrant □ Dependent of Seasonal □ Migrant Worker □ Seasonal Worker

7. **Email Address** ______________________________

8. ***(For reporting purposes only***) Annual Household Income __________ Family Size _____

9. **Adults Only: Do you have an Advanced Directive?** □ Yes □ No *If Yes, please provide a copy of the information to your healthcare provider to be placed in your medical chart.*

10. ReGenesis Health Care offers an In-house Pharmacy. If you would like your prescription(s) filled at our on site location, please check here □. If not, please list preferred pharmacy name, location and phone number:

____

ReGenesis Health Care will only communicate information regarding your care, or that of your minor child, to those individuals that you have authorized. Please list below the names of any relatives, as well as their relationship to you, that you authorize ReGenesis Health Care to communicate with regarding your care.

11. AUTHORIZE THE SHARING OF MY MEDICAL INFORMATION WITH THE FOLLOWING INDIVIDUALS:

Name: ____ Relationship:__________________

Name: ____ Relationship:__________________

Patient (Parent/Guardian) Signature________________________________ Date: _____________

12. PARENT/GUARDIAN INFORMATION

Name & Relationship of Adult Accompanying Child ______________________

List of persons having permission to obtain medical treatment for your child if you are unable to accompany your child. Person must provide picture identification at time of visit.

Name ______________________ Relationship ______________________

______________________ Relationship ______________________

13. How would you like to be contacted regarding appointments, treatment, or other information pertaining to your care?

____Mail ____Home Phone ____Work Phone

If you have an answering machine, may we leave a nonspecific message regarding appointments, or other information pertaining to your care? ____Yes ____No

If you do not authorize the use of any of these methods, then please list any alternate method we may use in contacting you:

____

Patient (Parent/Guardian) Signature____________________________________ Date: _____________

14. CONSENT FOR MEDICAL TREATMENT

I voluntarily consent to medical treatment and diagnostic procedures provided by ReGenesis Health Care and its associated physicians, clinicians and other personnel. I consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantee has been made to the result of treatments and examinations.

______________________ ______________________

Signature of Patient, Guardian or Legal Representative *Date*

If signed by other than patient, relationship to patient: ______________________

15. INSURANCE INFORMATION *(please provide copies of all medical insurance cards)*

*Co-payments are required at time of visit and/or payment for services not covered by insurance.

□Private Insurance □Self Pay □Workers Comp □Disabled □Other

Plan Name (Primary Insurance)____

Certificate/Plan Number _________________________________ Effective Date ____________________

Plan Name (Other Insurance) ____ Certificate/Plan Number __________________________________ Effective Date ___________________

16. GUARANTOR INFORMATION *(person financially responsible for any patient balances)* [ ] check if same as patient

Name __________________________________ Date of Birth _______________

Relationship to Patient ____________________________ Social Security # __________________

Mailing Address _______________________________

City ___________________ State ______ Zip _____________

Phone # Home __________________ Cell _____________ Best way to reach you? □Home □Cell

17 SUBSCRIBER INFORMATION *(person who carries the insurance)* [ ]check if same as patient

Name __________________________________ Date of Birth _______________

Relationship to Patient ____________________________ Social Security # __________________

Mailing Address _______________________________

City ___________________ State ______ Zip _____________

Phone # Home __________________ Cell _____________ Best way to reach you? □Home □Cell

*I authorize the release of any required medical information from my record to the above insurance company in order to process my claim. I understand that I am responsible for any charges not covered by insurance or other forms of benefits.

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Signature of Patient, Guardian or Legal Representative / Date