Integrity Health Group

HIPAA/Contact Update Form

This form will be valid until the patient listed turns 18. If there are any changes that need to be made a new form will need to be filled out. When patients turn 18 they will need to complete a new form themselves.

Patient Name ______________________________________ DOB: _____________ Patient cell: ________________

Patient Address ____

<u>Please provide the demographic information for the **insurance holder** for this patient:</u>

Name _______________________________________ Home Number: _____________________________

Relationship ____________________________________ Cell Phone Number: _________________________

Address ____ Work Number: ______________________________

Please provide the contact information for the people who we may speak to about your child's appointment and medical information. Please check off the boxes below for the ways we may contact all of these people

APPOINTMENT INFORMATION		MEDICAL INFORMATION	
Call Home Phone	□	Call Home Phone	□
Call Cell Phone	□	Call Cell Phone	□
Text Cell Phone	□	Text Cell Phone	□
Call Work Phone	□	Call Work Phone	□
Speak with another person that answers	□	Speak with another person that answers	□
Send via mail	□	Send via mail	□
Send via email/portal	□	Send via email/portal	□

<u>Primary Contact Person:</u> This is an Emergency contact person □ Primary # to Call

Name ______________________________ Home Number: _____________________________ □

Relationship __________________________ Cell Phone Number: _________________________ □

Address ______________________________ Work Number:______________________________ □

<u>Secondary Contact Person:</u> This is an Emergency contact person □ Primary # to Call

Name ______________________________ Home Number: _____________________________ □

Relationship __________________________ Cell Phone Number: _________________________ □

Address ______________________________ Work Number:______________________________ □

<u>Additional Contact Person (optional):</u> This is an Emergency contact person □ Primary # to Call

Name ______________________________ Home Number: _____________________________ □

Relationship __________________________ Cell Phone Number: _________________________ □

Address ______________________________ Work Number:______________________________ □

FLIP OVER →

Integrity Health Group

If you have any privacy preferences about any of these individuals please list them in the lines below:

____
____
____

Would you like to receive appointment reminders and medical information via calls or texts? If so please list the name and phone number of the person that will be receiving these (only one person can be listed):

Name: ____

Relationship: ____

Phone number for calls: ___________________________________

Cell Phone Number for texts: _______________________________

I attest that all the information I provided above is true and accurate to the best of my knowledge. I have received and am agreeable to the terms of Integrity Health Group's notice of privacy practices.

Signature: ____

Name: ____ Date: _____________________