Waterboro Village Pediatrics, LLC, PA

Patient Update Form — ADULT

SECTION 1: PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Sex: _____ Preferred Pronouns: _____ Language: _____ Race: _____

Ethnicity: _____ Email: _____
(Would you like to sign up for our Patient Portal? Please Circle: Yes / No)

Primary Phone: _____ Secondary Phone: _____
(Please circle: Cellphone / Landline) (Please circle: Cellphone / Landline)

Mailing Address: _____
(PO Box or Street, City/Town, State, Zip Code)

Home Address: _____
(Street, City/Town, State, Zip Code)

Pharmacy: _____
(Pharmacy Name & City/Location)

Are you attending college? Yes / No College: _____
(College Name & City/Location)

Employer Name: _____ Employer Phone: _____ Ext: _____

SECTION 2: EMERGENCY CONTACT INFORMATION

Name of Emergency Contact: _____ Relationship to Patient: _____

Primary Phone: _____ Secondary Phone: _____
(Please circle: Cellphone / Landline) (Please circle: Cellphone / Landline)

SECTION 3: INSURANCE INFORMATION

Primary Insurance: _____

Name of Policy Holder: _____

Secondary Insurance: _____

Name of Policy Holder: _____

Waterboro Village Pediatrics

Consent to Share Medical Information

We are not allowed to share your protected health information with family members or other persons unless you give us the express permission to do so. If you want to authorize a parent or other person(s) to have access to your medical information, you must complete this form.

I, _____, DOB: _____, give permission to **Waterboro Village Pediatrics** to share information regarding my health and medical treatment with the following person(s):

Name: _____ Relationship to Patient: _____

Can this person schedule appointments for you on your behalf? Please circle: Yes / No
Can this person refill your medications on your behalf? Please circle: Yes / No

Name: _____ Relationship to Patient: _____

Can this person schedule appointments for you on your behalf? Please circle: Yes / No
Can this person refill your medications on your behalf? Please circle: Yes / No

My INITIALS below **WILL ALLOW** information to be shared regarding:

_____ Mental Health Diagnoses & Treatments

_____ Medications including birth control

_____ Sexual activity

_____ All imaging results (x-ray, MRI, CT, etc)

_____ All lab results

Name of Patient (please print): _____

Signature of Patient: _____

Date: _____