Annual Update

*required info

Patient last name*: _____ **Patient first name*:** _____ **MI*:** ___

Preferred name (if different than above): _____

Date of birth*:_____

Marital status*: ☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ Partner ☐ Widowed

☐ Please check here if you prefer pronouns would you like (They/them/theirs) used in your health record.

Address*: _____ **Apt/Unit:** _____

City*: _____ **State*:** _____ **Zip*:** _____

Email address*: _____

Primary phone*: _____ ☐ Home ☐ Cell/mobile ☐ Work

Secondary phone: _____ ☐ Home ☐ Cell/mobile ☐ Work

How would you like to receive appointment reminder notifications?*

☐ Phone ☐ SMS/text[1] ☐ Both *OR* ☐ NO reminder notifications

[1]SMS/text messages may be subject to message or data fees charged by your mobile service carrier. Please contact your mobile service carrier to confirm any fees for SMS/text services.

Emergency contact*: _____ **Relationship*:** _____

Primary phone*: _____ **Secondary phone:** _____

Do you have a caregiver (if other than spouse or emergency contact)?

Name: _____ Phone: _____

Consent to Release Personal Health Information (PHI)*

I authorize Westminster Medical Clinic to discuss and/or share information with the individual(s) listed below. I understand that I may add or remove individual(s) to this consent at any time by submitting a new consent. I agree that Westminster Medical Clinic may share all information related to:

1. Medical, diagnostic, imaging, and/or laboratory results
2. Appointment scheduling and billing

Name: _____ Relationship:_____

Name: _____ Relationship:_____

_____ _____

PATIENT SIGNATURE (or legal guardian)* **DATE***