**WINTER PARK FAMILY PHYSICIANS**
5745 CANTON COVE, SUITE 121 WINTER SPRINGS, FL 32708
PHONE: 407-647-2550 FAX: 407-647-0616 Contact@wpfpllc.com

**DATE _____**

## PATIENT INFORMATION UPDATE

PATIENT NAME _____ MALE/ FEMALE DATE OF BIRTH:___/____/_____

NAME of Parent/ Custodian/ Spouse:_____

HOME ADDRESS _____CITY _____ STATE_____ZIP_____

BEST CONTACT NUMBER_____ CELL / HOME / WORK SS# _____

EMAIL ADDRESS_____

**EMERGENCY** **EMERGENCY**
CONTACT NAME _____ Phone #_____

ETHINICITY:_____ RACE:_____ PRIMARY LANGUAGE_____

INSURANCE _____ POLICY NUMBBER_____

POLICY HOLDER'S
HOLDER'S NAME _____ DATE OF BIRTH:___/____/_____

Employer
EMPLOYER :_____ OCCUPATION /TITLE: _____ Phone number_____

PREFERED PHARMACY _____ PHARMACY'S PHONE NUMBER_____

RELEASE OF CONFIDENTIAL INFORMATION

This is to inform you, that for your protection, it is our office policy not to release any information regarding your medical history or care to anyone without your permission. All medical information is kept confidential and in accordance to HIPPA Privacy Law, and practices. This includes spouses, parents of adult children, regardless of who is responsible for payment. We will, however, release information to other medical providers at their request, for continuity of medical care. If it is your desire that we discuss your medical care with someone other than yourself, please indicate below. Please list individuals in space provided below.

**PLEASE CHECK ONE:**

_____ **I DO NOT** wish you to discuss my medical care with anyone other than myself.

_____ You have my permission to discuss my medical care with the following individual(s):

Name _____ Relationship _____ Phone#_____

Name _____ Relationship _____ Phone#_____

**YES** **NO** I authorize to receive email/text/ voice mail messages for appointment reminders and general health reminders/feedback/ information (please circle)

**AUTORIZATION TO RELEASE OR OBTAIN MEDICAL INFORMATION**

**I hereby authorize Winter Park Family Physicians to release or obtain information that may be medically necessary in order to manage my care and/or process insurance benefits to or from other providers and/or medical facilities. I authorize direct payments of medical benefits for services to be rendered and I am aware, I am financially responsible for any balance that may not be covered by insurance (either copays or total amount of charges) if insurance does not pay.**
**ALL COPAYS ARE DUE AT TIME OF VISIT. IF NON INSURSED, PAYMENTS MUST BE TO BE PAID IN FULL PRIOR TO VISIT**

_____ _____
**Patient 's Signature** **Date**