# Orland Primary Care Specialists

**INTERNAL MEDICINE**
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# CHANGE OF PATIENT INFORMATION

**Date:**_____

**PATIENT:**

**Last Name:**_____ **First Name:**_____ **Middle Initial:**_____

**Date of Birth:**_____

**CHANGE OF ADDRESS:**

**Home Address:**_____ **City:**_____

**Home Telephone #:**_____ **State:**_____ **Zip Code:**_____

☐ Child Resides with Both Parents ☐ Child Resides with ☐ Mother ☐ Father ☐ Child Resides with Legal Guardian

_____

( Please list on the line above name of parent(s) or guardian(s) )

**Cell Phone # of Parent(s) or Legal Guardian(s):**_____ _____
Father or Guardian Mother or Guardian

**Work Phone # of Parent(s) or Legal Guardian(s):**_____ _____
Father or Guardian Mother or Guardian

**Email Address of Parent or LegalGuardian:**_____
(Please list one email address and name of the parent or guardian who's address is listed)

**Emergency Contact Name:**_____ **Relationship:**_____

**Emergency Contact Telephone #:**_____

**Please list all family members and their dates of birth related to these changes for address and/or insurance.**

**Patient Name:**_____ **Date of Birth:**_____

**Patient Name:**_____ **Date of Birth:**_____

**Patient Name:**_____ **Date of Birth:**_____

**Patient Name:**_____ **Date of Birth:**_____

**Patient Name:**_____ **Date of Birth:**_____

**Patient Name:**_____ **Date of Birth:**_____

**See backside of form for additional information requested regarding insurance changes and required signature confirmation**

**Please list previous plan(s) and coverage termination date:**

**Plan Name:**_____ **Date Coverage Terminated:**_____

**Plan Name:**_____ **Date Coverage Terminated:**_____

**CHANGE OF INSURANCE INFORMATION (Please present your new insurance card(s) to the receptionist for scanning)**

**PRIMARY INSURANCE** ☐ **Employee Group Policy** ☐ **Private Policy**

**Plan Name:**_____ **Policy Holder's Name**_____

**Policy Holder's Date of Birth:**_____ **Policy Holder's Relationship to the patient:**_____

**Policy Holder's Address ☐ same as patient Or** _____
**(Address, City, State, & Zip code if different from patient)**

**Policy ID #:**_____ **Group #:**_____ **Effective Date of Policy:**_____

**Primary Care Physician (HMO or POS Plans Only):**_____

**SECONDARY INSURANCE** ☐ **Employee Group Policy** ☐ **Private Policy**

**Plan Name:**_____ **Policy Holder's Name**_____

**Policy Holder's Date of Birth:**_____ **Policy Holder's Relationship to the patient:**_____

**Policy Holder's Address ☐ same as patient Or** _____
**(Address, City, State, & Zip code if different from patient)**

**Policy ID #:**_____ **Group #:**_____ **Effective Date of Policy:**_____

**Primary Care Physician (HMO or POS Plans Only):**_____

**I authorize the release of any medical information necessary to process my insurance claims. I authorize payment of medical benefits to Orland Primary Care Specialists and further understand I am financially responsible to Orland Primary Care Specialists for any copayments, deductible, coinsurance, or services not covered under my insurance. I understand that it is my responsibility to know my insurance benefits and whether or not the services my dependents receive are a covered benefit. I acknowledge the above listed information I have provided to be true and correct.**

_____ _____ _____
**Signature of Patient or Guardian** **Relationship to Patient** **Date**

_____
**(Please print name of patient or guardian who signed above)**