ANNUAL RECORDS UPDATE QUESTIONNAIRE

Revised May 2016

Providing appropriate, safe, and effective medical care is a shared responsibility between patient and provider/medical establishment. Patients are responsible for providing current, complete, and accurate information and then following their treatment plan. Provider/medical establishment responsibilities include ensuring that patients are fully informed of and consent to medical procedures, taking the patient's medical history into consideration as the treatment plan is developed, correct billing for services rendered, protecting patient's privacy, and conforming to federal, state, and medical board regulatory requirements.

For all of these reasons, it is essential that your records with us are current, complete, and accurate. Your records consist of 3 forms: Informed Consent to ensure you are fully informed of medical procedures and clinic policies; Medical History so that we can include your current medications and/or other medical considerations into your treatment plan; and Patient Information so we know how to contact you, who to bill for services rendered and other important information.

While maintaining current, complete, and accurate records is essential, we strive to do that in the most efficient and least cumbersome way possible. Accordingly, once a year we ask you to fill out a new Informed Consent form and then either confirm that nothing has changed on your Medical History or Patient Information forms, or to fill out new forms if anything has changed. This includes any changes to your Health Insurance plan, email or physical address, or phone numbers. In addition to the Annual Update, we also ask you to inform us each visit if anything has changed in your Medical History or Patient Information to include any changes to your health insurance plan.

PLEASE FILL OUT THE FOLLOWING:

PATIENT NAME (Please Print): ________________________________

I certify that there have been no changes since my last Medical History or Patient Information update to my:

- Medications, Medical Conditions, Medical Insurance
- Email, Physical Address, Phone Number
- My Emergency Contact Person(s)
- Person(s) I authorize you to speak to concerning my medical information such as lab or biopsy results

Patient Signature (18 or Older): ________________________________

DATE: ____________

Name of Parent/Legal Guardian or Representative (Please Print): ________________________

Parent/Legal Guardian or Representative Signature: ___________________________________

DATE: ____________

IF THERE HAVE BEEN CHANGES TO YOUR MEDICAL HISTORY OR PATIENT INFORMATION, PLEASE SEE THE FRONT DESK TO COMPLETE NEW FORMS.

Thank you for your understanding and assistance.