FAMILY FOCUS & ASSOCIATES

Patient Information Update

PATIENT INFORMATION

Last Name ______________________ First Name ______________________

Gender ______________________ Pronouns ______________________

Address ____

City ______________________ State __________ ZIP __________

Preferred Phone (   )   – __________ Email ______________________

INSURANCE PROVIDER

We are required to submit your insurance information when obtaining prior authorization for prescriptions. ***Please attach copy of insurance card, front and back.***

Insurance Company ______________________ Name of Insured ______________________

Member ID ______________________ Group Number ______________________

BIN # ______________ PCN # ______________ Medicare/Medicaid Y N

CREDIT CARD AUTHORIZATION

If more than one party will be responsible for payment, all parties should submit an authorization and indicate the percentage of each payment to be charged to each card.

Cardholder Name ______________________ Phone (   )   – __________

Card Number ______________________ Expiration ____/____ CVC ______

Debit ☐ Credit ☐ Visa ☐ Mastercard ☐ ZIP Code ______________________

Cardholder Signature ______________________ Percentage ______ %

______________________ ______________________ ____/____/____

SIGNATURE OF PATIENT
(or parent/guardian if a minor)

PRINTED NAME

DATE