



TODAY'S DATE _____

(Please Print)

UPDATED PATIENT INFORMATION

Patient's last name:	First:	Middle:	DOB:
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Street address/PO Box:	Home phone no.: ()	Cell phone no.: ()
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City:	State:	Zip:
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Preferred method of contact: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> E-Mail	Email Address:
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IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Best contact phone #:
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Any changes to your HIPAA form?

Yes, please make changes below. No

Name:	Relationship:	Phone #:
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1.		
2.		
3.		

Release of Information
 _____ (*initials*) My physician and authorized staff may disclose all or part of the patient's records to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient of physician(s) charges, including but limited to, insurance companies, worker's compensation carriers, auto insurance carriers, attorney or the patient's employer.

Patient Portal
 _____ (*initials*) I am aware that by providing my doctor's office with my current email, I will have access to my secure medical chart via the patient portal. I will be able to access my appointment request or reminders, prescription refills, non urgent medical questions, lab results, and more.

Electronic Prescribing
 _____ (*initials*) Jupiter Medical Group, PA is enrolled in an electronic prescribing program. This program is meant to help our providers with understanding what medications our patients are currently using and to provide the best possible treatment. I give Jupiter Medical Group, PA permission to request and use my prescribing medication history from other healthcare providers.