

Southern Oregon Rheumatology Clinic, SORC

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NOTIFICATION OF PATIENT INSURANCE CHANGE

*This form is to be used for the purpose of demographic and insurance changes only;
all other information from the original registration form is on file for your review and can be updated per your request*

Patient Name _____ Date of Birth: _____ Social Sec # XXX-XX-_____
Last, First, Middle

PRIMARY INSURANCE

(Patient's own insurance policy or spouse's if "not" employed)

Name of Insurance _____ ID# _____ Group # _____

Subscribers Name _____ Subscriber's Social Security # _____

Relationship to Patient _____ Subscriber's Birth Date _____

Address (if different from patient) _____ Phone () _____

Subscribers Employer _____ Work Phone () _____

SECONDARY INSURANCE

*(Are you covered by additional insurance? **If yes**, complete this section)*

Name of Insurance _____ ID# _____ Group # _____

Subscribers Name _____ Subscriber's Social Security # _____

Relationship to Patient _____ Subscriber's Birth Date _____

Address (if different from patient) _____ Phone () _____

Subscribers Employer _____ Work Phone () _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits directly to my healthcare provider who accepts assignment.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Responsible Party Signature

Relationship to patient

Date

I attest that the above information is true and correct to the best of my knowledge