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

Revised 12-15,
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