DEMOGRAPHIC INFORMATION UPDATE FORM

(Please Print)

Today's date:				Account#:		
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:		Home phone no.: ( )		
P.O. box:	City:	State:	ZIP Code:			
Is the Patient a minor? If so:	Parent/Legal Guardian Name:					

FINANCIAL INFORMATION

1. Do you have Insurance, Medicare or Medicaid that you wish to have billed for the services provided?

   (If yes, please complete the Authorization of Benefits Form.)

2. Would you like a LifeMed Billing Specialist to contact you to discuss your account?

CERTIFICATION

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to LifeMed Alaska. I understand that I am financially responsible for any balance. I also authorize LifeMed or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*