**Rhode Island Medicine, Inc.**
**Patient Information Update Form**

**NAME:** ________________________________ **DOB:** ______________ **AGE:**_______ **SOC SEC**:____________________

**TEL:** (home):_____________________ (work/cell):______________________ **EMAIL:** _______________________________

**ADDRESS:** ____________________________________________________________________________________
Street City State Zip

**EMPLOYER INFORMATION:**____________________________________________________________________________
Company Name Phone

____________________________________________________________________________________
Street City State Zip

**OCCUPATION:** ________________________________ **FULL TIME?**_______ **PART TIME?**_______

**LANGUAGE:**__________________________ **ETHNICITY: [Please Circle One]** Hispanic Non-Hispanic

**RACE: [Please Circle One] (**American Indian or Alaska Native) (Asian) (White) (Black or African American) (Native or Pacific Islander) (Other Race)

**Preferred Pharmacy**:_______________________ **Location:**____________________________________

**Do you or a spouse receive Veteran's Benefits?** (YES) (NO)

Do we have permission to release any of your medical information to any friend or relative? _______________
If yes, please list below:

______________________________________________ ______________________________________________
Name Relationship Name Relationship

**EMERGENCY CONTACT (must have different contact information than you):**

____________________________________________________________________________________
Name Relationship Telephone

____________________________________________________________________________________
Name Relationship Telephone

I have read and understand your 'Notice of Privacy Policy'.

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

Effective January 1, 2011, a **late fee of $25** will be assessed for co-pays that are 30 days past the due date.

Effective August 1, 2012, a **fee of $20** will be assessed to any appointments that are **missed** or **cancelled** without **24 hours** notice**.**

I consent to treatment by Rhode Island Medicine for my medical conditions.

I give Rhode Island Medicine, Inc. permission to use my protected health information for purposes of treatment, payment and health care operations. I am free to revoke this authorization at any time in writing.

____________________________________________________________________________________
Signature Date