

Annual Demographic Update Form

Full Address: City: State: Zip:		DOB:	Marital Status	5:
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RACE: Native American, Indian, Alaskan Native, Asian, African American, Caucasian, Refused to Report, Other:	er provided ()	•		rmation on my voicemail
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Insurance Company: Policyholder's Name: Group #: Relationship to Policyholder: Policyholder's DOB: Secondary Insurance Insurance Company: Policyholder's DOB: Policyholder ID#: Policyholder's Name: Group #: Relationship to Policyholder: Policyholder's Name: Relationship to Policyholder: Policyholder's DOB: Ithorization/Assignment/Financial Responsibility If your insurance requires a specified primary care physician or PCP, then you must have Nature Coast Health Care designated as your PCP prior to your appointment. We automatically file all insurance as a courtesy to you. However, our office cannot accept responsibility for negotiation of claims with insurance companies or other partic have any questions concerning your coverage and/or covered services, please contact your insurance company. We cannot determine what your plan coverage involves. patient's responsibility for find out if our office participates with their insurance plan and what the policy covers. If we do not participate with your insurance is so we are contracted with. We file insurance claims electronically by computer and on paper; your signature at the bottom of this page gives us permission to do so. Contract To Pay for Medical Services: I have read, and I understand the above office policy concerning my insurance. I understand that I am fully responsible for payment professional services rendered to me by Family Care Physicians. If insurance is filed for me, I authorize release of information to my insurance carrier, as well as direct payl benefits to Nature Coast Health Care for the services rendered.	YE A LIVING WILL? YES	NO***		
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