



### ESTABLISHED PATIENT UPDATE SHEET

Patient's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Last First Middle

Mother's Name: \_\_\_\_\_ Cell: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street city zip

Online patient portal Email: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Cell: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street city zip

Online patient portal Email: \_\_\_\_\_

**Preferred phone number for us to call or Text You:** \_\_\_\_\_

#### Other Children in Family:

Name	Last	First	Birth Date	Name:	Last	First	Birth Date
1.	_____	_____	_____	4.	_____	_____	_____
2.	_____	_____	_____	5.	_____	_____	_____
3.	_____	_____	_____	6.	_____	_____	_____

**Guarantor's Name** \_\_\_\_\_ **Relationship to patient** \_\_\_\_\_

**Insurance Company Name:** \_\_\_\_\_ **Effective date** \_\_\_\_\_

**Policy Holder Name:** \_\_\_\_\_ **Birth date:** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_

**Group No:** \_\_\_\_\_ **Member ID No:** \_\_\_\_\_ **Co-Pay** \_\_\_\_\_

#### INSURANCE AUTHORIZATION, ASSIGNMENT & TEXT FROM OFFICE:

I hereby authorize Dr. Bharani to treat my child/children for any illness in my absence and furnish information to insurance carriers concerning my child's illness and treatments and I hereby assign to the physician all payments for medical services rendered to my dependents. I hereby AUTHORIZE Dr Bharani's Office contact us via text and/or by patient portal. I am aware child's name will appear on Text.

\_\_\_\_\_  
Signature of Parent/Legal Guardian Relationship Date: \_\_\_\_\_