Blossomwood Medical
primary care for adults

2021 Information Update
General Information:

Name: _____

Preferred Name: _____

DOB: _____ SS#: _____

Address: _____

City, State, Zip: _____

E-Mail to opt into patient portal:_____

Primary Phone: _____ Secondary Phone:_____

Sex (circle one): Male Female Transgender

Marital Status: Married / Single / Divorced / Widowed

Is it okay to leave a voicemail about your upcoming appointment? _____

Do you need to make any changes to your HIPAA form? _____

Insurance Information

If the primary cardholder is someone other than yourself, please complete the following:

Name of Primary Cardholder:_____

DOB: _____ **SS# :** _____

I understand by signing this form I acknowledge that my **copay is due at time of appointment**. I also acknowledge that is my responsibility to notify Blossomwood Medical of any changes to my insurance and address. All outstanding balances must be paid in full or a payment arrangement has to be made in order to continue being treated.

_____ _____

Signature Date