CABOT MEDICAL CARE
UPDATE PATIENT INFORMATION (USE DARK BLUE OR BLACK INK)

Patient's Last Name_____First_____MI____DOB____/___/____

SS#_____ Address_____City_____

State_____ Zip Code_____ E-mail_____

Home Phone (____)_____Cell (____)_____Work(___)_____
Preferred Contact: Home # / Cell# / Work# / Portal **Preferred Reminder:** Home # / Cell# / Work# / Text / Portal

My Primary Care Doctor is:
Dr. Blair Dr. McCutcheon Dr. Robertson Dr. Merrick Dr. Shotts Dr. Stamp Dr. Holloway Dr. Walter

Preferred Pharmacy Name and Location_____

Spouse's Name_____ Phone (_____)_____

Emergency Contact _____Phone (_____)_____Relationship_____
If the patient is a minor, please provide the following information on the patient's parent or guardian:

Father's Name_____SS#_____DOB_____Phone(____)_____

Mother's Name_____SS#_____DOB_____Phone(____)_____

Address if other than patient's_____City_____State_____Zip_____

HIPAA Authorization

I hereby designate the following person(s) to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me. This agreement will remain in place until you, as the patient revoke this in writing.

_____ _____
Print name & phone number of personal representative Relationship

_____ _____
Print name & phone number of personal representative Relationship

_____ _____
Print name & phone number of personal representative Relationship

_____ _____
Signature Date