HARDER family practice P.A.

# RENEWAL PATIENT FORM

## PATIENT INFORMATION

Legal Name: _____ _____ _____ Date Of Birth: _____/_____/_____
Last First MI

Birth Sex: M___ F____ Social Security #: _____ -_____-_____ Marital Status: S ____ M ____ D ____ W ____ Other ____

Address _____ City _____ State _____ Zip Code _____

Preferred Phone Number: (____)_____ Email Address _____

Preferred Contact and Reminder Method (check one): Phone _____ Mail _____ Text _____

## INSURANCE INFORMATION

Primary Insurance Company: _____ Policy Hold ID: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder: Date of Birth _____ Social Security Number _____ Phone Number_____

Secondary Insurance Company: _____ Policy Hold ID: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder: Date of Birth _____ Social Security Number _____ Phone Number_____

## RESPONSIBLE PARTY INFORMATION

Complete this section if you would like billing information to be sent to someone **OTHER THAN THE PATIENT.**

Name _____ Relationship _____ DOB ____-____-_____

Address _____Apt _____ City _____ State _____ Zip _____

Preferred Phone Number (_____)_____ Email: _____

## CONSENT TO CONTACT

I give Harder Family Practice, PA permission to speak to the following person/person's regarding any pertinent medical information.

Name: _____ Relationship to patient: _____ Phone Number: (___)_____

Name: _____ Relationship to patient: _____ Phone Number: (___)_____

_____ _____
**Signature of Patient or Parent/Guardian** **Date**

Effective January 1st, 2023 any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice prior to the scheduled appointment will be considered a No Show and will be charged a $25.00 fee. This fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.