PATIENT UPDATE INFORMATION SHEET

Patient's Name _____ Date of Birth _____

Street Address _____ Social Security _____

City, State & Zip _____ Home/Cell Phone _____

Drivers License Number _____ Work Phone_____

Email_____

Please read the following authorization and sign for our file:

I hereby authorize payment directly to Dr. Gary W. Duncan of the medical and surgical benefits otherwise payable to me but not to exceed the charges made for such treatment. I understand that I am financially responsible for the charges not covered by my insurance. I understand that I will be charged a 30% fee for collections of any unpaid charges.

Signature: _____ Date: _____

I hereby authorize Dr. Gary W. Duncan to release to my insurance company any information required, including the diagnosis and records in the course of my examination or treatment.

Signature: _____ Date: _____