



Medical Update Form

Name

Social Security Number

Physician/Staff Information

1. Please list the doctors and staff you currently see and the names of the facilities that you CURRENTLY go to.

⊗ Physician/Staff 1

Facility/Clinic/Office Name

Telephone Number

Doctor's/Staff's Full Name

MD., OD., PhD, PA-C or NP

MD. OD. PhD PA-C NP

Street Address

 

Why do you see this doctor?

Appointment Type

- First Appointment
 Most Recent Appointment

Appointment Date**Appointment Type**

- First Appointment
 Most Recent Appointment

Appointment Date**Will you see this doctor for another appointment in the future?**

- Yes No

Future Appointment Date

+ Add Physician/Staff

Hospital Information

2. Please list any emergency room visits or hospitalizations since our last medical update.

⊗ **Hospital 1**

Hospital/Urgent Care Facility Name**Telephone Number****Hospital/Urgent Care Facility Address****Why did you visit this hospital?**

Treatment Type

- Emergency Room
- Inpatient/Hospitalized Outpatient

Treatment Date

Treatment Type

- Emergency Room
- Inpatient/Hospitalized Outpatient

Treatment Date

Treatment Type

- Emergency Room
- Inpatient/Hospitalized Outpatient

Treatment Date

+ Add Hospital

Medications

3. Please list all medications that you are CURRENTLY taking.

Name of Medication**Prescribing Doctor**

+ Add Item

4. What year did you last file a tax return? How much were your earnings for that year?

Year You Last Filed a Tax Return**Earnings for That Year**

5. What is your height and weight?

Height**Height****Weight**

6. Has there been significant changes in your condition since our last contact? Any new diagnoses?

Significant Changes in Condition

Yes No

New Diagnoses

Yes No

7. Are you currently working or have you attempted to work since our last medical update?

Choose One

Yes No

8. Please list all amounts and sources of your current household income.

Annual Tax Refund

You

Spouse

Other

Monthly SDA

You

Spouse

Other

Monthly Bridge Card

You

Spouse

Other

Monthly Unemployment

You

Spouse

Other

Monthly Child Support

You

Spouse

Other

Monthly Alimony

You

Spouse

Other

Monthly VA Benefits

You

Spouse

Other

Workers' Compensation

Choose One

- Monthly
- Lump Sum

You

Choose One

- Monthly
- Lump Sum

Spouse

Choose One

- Monthly
- Lump Sum

Other

Long/Short Term Disability

You

Spouse

Other

Other Types of Income

⊗ Income Source 1

List Type of Income Source Below

Choose One

Weekly

Monthly

Annually

You

Choose One

Weekly

Monthly

Annually

Spouse

Choose One

Weekly

Monthly

Annually

Other

+ Add Income Source

9. Have you had a change in marital status?

Choose One

Yes No

10. Please list your current contact information.

Address



Telephone Number

Alternate Telephone Number

Emergency Contact Full Name

Emergency Contact Telephone Number

Additional Information