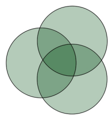


Dean Chier, MD

PATIENT CHANGE OF ADDRESS

Please fill out completely

First Name: MI: Last Name:

Address: City, State, Zip:

Email: Mobile Phone: MSG OK? ( ) Yes ( ) No

Date of Birth: Home Phone: MSG OK? ( ) Yes ( ) No

Gender Identity: Work Phone: MSG OK? ( ) Yes ( ) No

Employment: ( ) Employed ( ) F/T Student ( ) P/T Student ( ) Retired ( ) Other

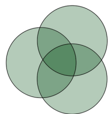
Marital Status: ( ) Single ( ) Married ( ) Partnered ( ) Divorced ( ) Widowed ( ) Dependent

Responsible Party: Phone:

Address: City, State, Zip:

Emergency Contact: Email: Phone:

Signature: Date:



Dean Chier, MD

PATIENT INSURANCE UPDATE/CHANGE

Please fill out completely

First Name: MI: Last Name:

Insurance Company Name: ( ) Primary ( ) Secondary

Subscriber Name:: Subscriber Date of Birth:

Relationship to You: ( ) Partnered ( ) Divorced ( ) Widowed ( ) Dependent

ID # As Shown on Card: Group #:

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assessed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature: Date: