UB|MD INTERNAL MEDICINE

Chart Update Information

PATIENT NAME	BIRTH DATE / /

THANK YOU FOR PARTNERING WITH UBMDIM IN YOUR HEALTHCARE

We appreciate your help in keeping your chart up to date by providing the below information.

PHARMACY USED

Local:

Mail order: ☐ check if no mail order is used

YOUR CARE TEAM/OTHER PROVIDERS YOU SEE

PLEASE INCLUDE ANY OTHER SERVICE PROVIDERS AS WELL—OXYGEN COMPANY, VISITING NURSE, ETC.

Name	☐ check if visit occurred since last here
Name	☐ check if visit occurred since last here
Name	☐ check if visit occurred since last here
Name	☐ check if visit occurred since last here
Name	☐ check if visit occurred since last here
Name	☐ check if visit occurred since last here

HAVE YOU HAD ANY: TESTING, HOSPITALIZATIONS, ER/URGENT CARE VISITS SINCE YOUR LAST VISIT HERE?

Test: _____ Location: _____ Date: _____

Test: _____ Location: _____ Date: _____

Hospital: _____ Dates: _____

Hospital: _____ Dates: _____

ER/Urgent Care: _____ Date: _____

DO YOU HAVE A HEALTH CARE PROXY? This identifies who can speak for you if you can't speak for yourself to make medical decisions.

IF YOU DO	IF YOU DO NOT
• and it has been updated since your last visit, please bring it with you. • and it is current and we have a copy—you're all set!	• we will plan to discuss this at your upcoming visit. • more information is available at: https://www.health.ny.gov/forms/doh-1430.pdf

DO YOU HAVE A LIVING WILL OR ADVANCED DIRECTIVES? MOLST (Medical Orders for

Life-Sustaining Treatment)	
IF YOU DO • and it has been updated since your last visit, please bring it with you. • and it is current and we have a copy—you're all set!	IF YOU DO NOT • we will plan to discuss this at your upcoming visit. • more information is available at: https://www.health.ny.gov/forms/doh-5003.pdf

HAVE YOU MADE US AWARE OF FAMILY AND FRIENDS WE ARE AUTHORIZED TO SHARE YOUR INFORMATION WITH BY FILLING OUT A HIPAA FORM?

☐ check if this was done and is up to date OR fill out the below

Name	Relationship	Primary phone	Secondary phone

ARE YOU USING OUR SECURE PATIENT PORTAL?

☐ Yes	☐ No
• we would appreciate any feedback on this service below.	You can use the portal to request appointments, request refills, send messages to your provider, and view some of your lab and test results. By providing your email below, we can send you an email invitation. Your password is the year of your birth. email address: _____

AUTHORIZATION TO LEAVE MESSAGES

PLEASE COMPLETE IF NOT DONE PREVIOUSLY

From time to time it may be necessary to leave you a message concerning appointment, financial issues, or other protected health information (PHI). Please indicate how you prefer we leave a message for you:

	Phone Number	May we leave a voice message?	May we leave a message with another person answering this phone?
Voice Mail on Preferred Phone Number	- -	☐ Yes ☐ No	☐ Yes ☐ No
Voice Mail on Alternate Phone Number	- -	☐ Yes ☐ No	☐ Yes ☐ No
		May we send a message?	
Send through UB Mail		☐ Yes ☐ No	

SIGNATURE

_____ _____

Signature **Date**