PACIFIC SHORES MEDICAL GROUP
Physician Information Update Form

Treating Physician:_____ Clinic:
Date: _____ Account #:
Patient Name: DOB: Age: Gender:

Dear Mr/Ms_____

In order for us to communicate with other doctors who care for you, it is important that we update their names on file. Please write down in the spaces provided below the full name of the doctor(s) involved in your medical care, their specialty, and phone number.

If you have a primary care physician (PCP), please write the name in the first row as shown; write all other doctors' names in the following rows as requested. Please write your initials at the bottom of this form.

Primary Care Physician On Record

Name	**Phone number**

_____

If this information is not correct, please indicate the correct information in the space provided below:

First Name	**Last Name**	**Specialty**	**Phone number**

Please Also Indicate Your Other Physicians:

First Name	**Last Name**	**Specialty**	**Phone number**

Comments:_____

_____

PATIENT/CAREGIVER INITIALS:_____