Notice of Patient Demographic Change

Name of Person requesting change:
Please attach a copy of your ID

Last: _____ First: _____

Relationship to Patient: _____ Email address: _____

Patient Name (If this information needs to be changed, please write in the patient's previous name):

Last: _____ First: _____

Patient's Date of Birth (If this information needs to be changed, please write in the patient's previous Date of birth):

(MM/DD/YYYY): __ __ / __ __ / __ __ __ __

Signature:_____
Today's Date:

(MM/DD/YYYY): __ __ / __ __ / __ __ __ __

Please only fill in the rows that need to be changed:
****For any changes to Legal Name and/or DOB, please attach the patient's birth certificate/legal documentation.**

Information to Update	Previous	New
Legal Name**		
Name Used		
Date of Birth**		
Sex at Birth	☐ Female ☐ Male ☐ Unknown ☐ Intersex ☐ Nonbinary	☐ Female ☐ Male ☐ Unknown ☐ Intersex ☐ Nonbinary
Gender	☐ Girl/Woman ☐ Boy/Man ☐ Transgender Girl/Woman ☐ Transgender Boy/Man ☐ Genderqueer/Gender Diverse ☐ Nonbinary ☐ Agender ☐ Unsure ☐ Not Listed :_____ ☐ Decline to State	☐ Girl/Woman ☐ Boy/Man ☐ Transgender Girl/Woman ☐ Transgender Boy/Man ☐ Genderqueer/Gender Diverse ☐ Nonbinary ☐ Agender ☐ Unsure ☐ Not Listed :_____ ☐ Decline to State

Information to Update	Previous	New
Pronouns	☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Not Listed :_____	☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Not Listed :_____
Address		
Guardian 1		
Guardian 2		
Other: _____		

Information for this patient will be completely or slightly changed. ; However, Documents prior to the change may still show previous information. Name Used and Pronouns are not confidential. They will be on the patient wristband and can be seen in the Electronic Medical Record.
While we recognize all gender identities, many insurance companies and legal organizations do not. Please be aware that the legal name and sex listed on your insurance must be used for billing communication with the insurance company, and for providing necessary documents. If you do not have insurance, list what is on your government-issued ID (such as driver's license)

HIM Use Only ----------
----------**Patient's MRN:**
Date of Change: **Employee:**