



NAME CHANGE REQUEST

Please provide a copy of the supporting legal documentation of the name change requested, and complete the information below. Please mail (address below) or fax (630-836-0667) the supporting documentation and this form to our office for proper processing.

PLEASE PRINT

Today's Date: _____

Patient Date of Birth: _____

Patient name currently on record at PTC: _____

Request PTC to change above name to: _____

Address/Phone changes Yes / No

If any address or phone number changes please provide below:

Patient Signature _____

(if over 18 years of age)

Guardian Signature _____

(if under 18 years of age)

For office use only:

Date received:

FD

MR

PTC

RX

4575 Weaver Parkway, Warrenville, Illinois 60555-4039

630-505-0300 – 866-504-6076 – Fax: 630-836-0667

www.hriptc.org