INITIAL POINT FAMILY MEDICINE
PATIENT INFORMATION SHEET

Patient Name: _____ Date: _____
First Middle Last

Mailing Address: _____ City/State/Zip: _____

Primary Telephone: ( ) _____ Secondary Telephone: ( ) _____

Birth Date: _____ SSN#: _____ Race: _____ Ethnicity: _____

Language: _____ Occupation: _____ Employer: _____

Work Phone: ( ) _____ E-mail: _____

Do you want to sign up for the Patient Portal to view labs, statements, etc. online? Yes_____ No_____

Name of Partner/Spouse: _____ Employer: _____

Primary Telephone: ( ) _____ Secondary Telephone: ( ) _____

Emergency contact, if not partner/spouse above: _____ Relationship: _____

Primary Telephone: ( ) _____ Secondary Telephone: ( ) _____

Complete this section only if someone other than patient is financially responsible.

Responsible Party: _____ Relationship to patient: _____

Mailing address: _____ City/State/Zip: _____

Primary Telephone: ( ) _____ SSN#: _____ Birth Date: _____

INSURANCE INFORMATION

Primary Insurance: _____

Address: _____ City/State/Zip: _____

Policy ID#: _____ Group#: _____

Secondary Insurance: _____

Address: _____ City/State/Zip: _____

Policy ID#: _____ Group#: _____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember you are responsible for all deductible, co pay and non-covered service amounts. See our complete financial policy for details.

Patient Signature (or guardian if under 18)_____ Date: _____

If *updating information, please initial and date below:*

Initials/Date: _____ Initials/Date: _____ Initials/Date: _____