PATIENT INFORMATION SHEET

Patient Name:____Date: ____________________
First Middle Last

Mailing Address:_____________________________________City/State/Zip: _________________________

Primary Telephone: ( )______________________Secondary Telephone: ( ) ________________________

Birth Date:________________Race:_____________Ethnicity:_________ Language:______________________

Occupation:__________________________________Employer: _____________________________________

Work Phone: ( )_____________How did you hear about our office?_________________________________

Preferred Pharmacy:____________________________Location:______________________________________

We recommend you sign up for the Patient Portal to view labs, statements, etc. online, would you like to sign up? (Must be at least 18 years old) Yes___ No___ E-mail: ____

How do you prefer to be notified of lab results (i.e. phone call, mail, patient portal)?________________________

Emergency Contact: _____________________Phone:__________________Relationship:_________________

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I give permission for Initial Point Family Medicine to provide any information about my medical condition, medical needs, medications or the status of my account to the following individual(s):

Name of Designated person: _________________________Relationship:__________Phone:___________________

Name of Designated person: _________________________Relationship:__________Phone:___________________

☐ I decline any release of information (This does not apply to covered entities listed in the HIPAA rules at 45 CFR 160.103)

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

Responsible Party:_________________________________Relationship to patient: _______________________

Mailing address:____City/State/Zip: ________________________

Primary Telephone: ( )______________________Birth Date: __________________________

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: _______________