Centerpoint
FAMILY PRACTICE
Convenient, Family-Centered Medical Care

New Patient Information

Patient Name: _____ **Marital Status:** S M D W

Last First MI

Date of birth: _____ **Social Security number:** _____

Address: _____**Apt#**_____

City: _____ **State:** _____ **Zip:** _____

Phone: Home (___)_____

Cellphone (___)_____ May we text you reminders of upcoming appointments? **Y / N**

Work (___)_____

Email Address: _____

Employer: _____ **Occupation:** _____

Race: O White **Gender:** O Male **Ethnicity:** O Hispanic or Latino

O Black O Asian O Female O Not Hispanic or Latino

O American Indian or Alaska Native

O Native Hawaiian or other Pacific Islander

O Other or mixed

Preferred language: O English

O other_____

Spouses Name or Parent Name, if child: _____

Is this the person responsible for the bills? O Yes O No, bill patient

Address, if different than patient_____

Date of birth: _____ Employer: _____

Work Phone (_____)_____ Cell (_____)_____ SS# _____

Would you like to be reminded of upcoming office visits? O Yes O No

If so, **which method do you prefer?** O Home Phone O Cell Phone O Work Phone
(Check all that apply): O Mail O Email

May we leave a message (voice-mail) for you regarding test results, reminders, etc.? O Yes O No

If so, which method do you prefer? O Home Phone O Cell Phone O Work Phone
(Check all that apply): O Mail O Email

Do you have an Advance Directive (Living Will)? O Yes O No

(If yes, please provide our office with a copy for your records at your earliest convenience.)

Please list your medical insurance company(companies)

1._____Insured_____Policy#_____Grp#_____

2._____Insured_____Policy#_____Grp#_____

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