BridgePoint Health

Today's Date ________________ **Information Sheet** Intake Initials ______________

Appt Date: ________________ Time: ____________ MD/Therapist ____________________________
(preference/reason)

Patient's Name: ____ D.O.B. ______________ M/F

Street Address: ____ Apartment: ______________

City: ______________________________ State: ________ Zip: ________ Marital Status: M S D W

Home Telephone: ____________________ Ok to call home: yes no Ok to leave message: yes no

Employer: __________________________ Telephone: ________________ Ok to call work: yes no

Social Security Number: ____________________ Reason for visit: ______________________________
***If for Disability Determination______________**
***Allow 1 hour and 15 minute appointment time.**

Spouse/Parent/Legal Guardian Name: ____

Referring MD/Agency: ________________________ Primary Care MD: __________________________

Responsible Billing Party Name: ________________________________ Relationship: ______________

Street Address: ____ Apartment: ________________

City: _________________________ State: ____________ Zip: ____________ DOB: _______________

Contact person not living with you (for emergencies): ________________ Telephone: ______________

Primary Insurance: ____ Telephone: ______________

Insured Name: _________________________ DOB: ________________ Employer: _________________

Relationship: ____________ Policy # __________________________ Group # ____________________

Secondary Insurance: ____ Telephone: ______________

Insured Name: _________________________ DOB: _________________ Employer: ________________

Relationship: ____________ Policy # ___________________________ Group # ___________________

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Patient's Signature: ____ Date: ________________

Parent/Legal Guardian's Signature: ____________________________________ Date: ______________

How did you hear about us? Please circle
***Family *Physician *Website *Yellow Book *Insurance Co. *Friend *Other** ________________

BPH 2/08