

Sand Point Internists

4915 25th Ave NE #301

Seattle, WA 98105

206-524-4737

10330 Meridian Ave N #230

Seattle, WA 98133

206-524-4737

PLEASE COMPLETE ALL SECTIONS

Today's Date: _____ Mr. ___ Mrs. ___ Ms. ___ Miss ___ Dr. ___ Rev. ___

Last Name _____ **First** _____ **Middle I** _____

Address: _____

City: _____ State: _____ Zip Code: _____

Male ___ Female ___ Employer: _____

Home telephone: () _____ Work Telephone: () _____

Birth Date ___/___/___ Social Security # _____

Single ___ Married ___ Divorced ___ Widowed ___

EMERGENCY CONTACTS

Spouse's ___ Parent's ___ Name: _____

Address: _____ Telephone: () _____

Who should we contact in case of an emergency other than listed above?

Name: _____ Telephone: () _____

Relationship: _____

BILLING INFORMATION

Person Responsible for Payment: _____

Billing Address: _____ Telephone: () _____

Name of Insurance Company: _____

Address of Insurance Company: _____

PolicyHolder Name: _____

Identification Number: _____ Group Number: _____

I hereby authorize payment directly to the physician for any benefits available under my insurance, and to release any information necessary to determine benefits. I am financially responsible for all non-covered services.

I, the patient/patient's legal representative, hereby grant permission to Dr.'s Frank K. Mitchell, Joan E. Olson, Sarah K. Pohlmann, Gurinder P. Sahi, Anita S. Uppal, Donna Richman, MD, Emily L. Cooper, MD DBA Sand Point Internists, to perform such examination and medical/therapeutic procedures as may be professionally deemed necessary or advisable for my/the patient's diagnosis and treatment.

I acknowledge receipt of Privacy Practice Notice.

Signature: _____ Date: _____