

**Shoreline Family Medicine**  
5933 Grand Haven Road – Muskegon, Michigan 49441  
(231) 799-3300 / Fax (231) 799-3322

**NEW PATIENT INFORMATION SHEET**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact and Phone: \_\_\_\_\_

**Medical:** Indicate your current and/or previous physicians over the last 5 years (start with most recent)

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Reason for leaving current physician: \_\_\_\_\_

How many times have you been to either ER or Medi-Center in the last 12 months? \_\_\_\_\_

Reason for visits: \_\_\_\_\_

List your ongoing illnesses (i.e. back pain, diabetes, migraines, hypertension, asthma, etc.):

\_\_\_\_\_

List the medications you are currently using (both prescription and over the counter):

\_\_\_\_\_

\_\_\_\_\_

**Insurance:** Current Insurance company: \_\_\_\_\_

Contract/ID #: \_\_\_\_\_

Did someone refer you to this office? \_\_\_\_\_ If yes, name \_\_\_\_\_

Do you prefer a male or female provider? \_\_\_\_\_

*\*Important Notice: The completion of this form does not establish you as a patient of Dr. Powell or Shoreline Family Medicine. The information requested is necessary for administrative and medical decision making. If an appointment time is scheduled for you, it will be contingent upon administrative approval, insurance participation and verification of current insurance coverage.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_