PATIENT INFORMATION

Name: _____

Sex: _____ Date of Birth: _____

Social Security #:_____

Address: _____

Apt # _____ City: _____

State: _____ Zip: _____

Primary Phone: _____

Primary Phone Type: Cell Home Work

Secondary Phone: _____

Secondary Phone Type: Cell Home Work

Email: _____
(Email addresses listed here are used for appointment reminders and newsletters only)

Preferred Contact Method: Cell Home Work Email

Race: _____ Ethnicity_____

Preferred Language: _____

Employer: _____

Relationship Status: Married Single Divorced Other

PARENT/GUARDIAN INFORMATION (REQUIRED IF PATIENT UNDER 18 YEARS OF AGE)

Name: _____

Relationship to patient: _____

Sex: _____ Date of Birth: _____

Social Security #:_____

Address: _____

Apt # _____ City: _____

Primary Phone: _____

Phone Type (Circle one): Cell Home Work

EMERGENCY CONTACT [ ] Same as Parent/Guardian

Name: _____

Relationship: _____

Phone number: _____

_____

Patient Signature

_____

Parent/Guardian Signature (If other than Patient)

_____

Date

PRIMARY INSURANCE

Ins Co. Name: _____

Member ID: _____

Group #:_____

Phone number: _____

Do you have any other insurance? _____NO _____YES

PRIMARY POLICYHOLDER

[ ] Same as Patient [ ] Same as Parent/Guardian [ ] Other

Relationship to Patient: _____

Name: _____

Sex: _____ Date of Birth: _____

Social Security #:_____

Address: _____

Apt # _____ City: _____

State: _____ Zip: _____

Primary Phone: _____

Phone Type (Circle one): Cell Home Work

Employer: _____

GUARANTOR

The individual responsible for payment of charges incurred for services rendered at our office. If this is someone other than the Primary Policyholder, please list their information below.

Relationship to Patient: _____

Name: _____

Sex: _____ Date of Birth: _____

Address: _____

Apt # _____ City: _____

State: _____ Zip: _____

Primary Phone: _____

Phone Type (Circle one): Cell Home Work

New Patients: How did you hear about VHP or VP?

- ☐ Google
- ☐ VHP Website
- ☐ Advertisement
- ☐ Health Fair
- ☐ Employer
- ☐ E-mail
- ☐ D Magazine
- ☐ Insurance Website
- ☐ Direct Mail
- ☐ Angie's List
- ☐ Physician Referral
- ☐ ZocDoc, 1-800 Doctors, RateMD
- ☐ Family/Friend:_____
- ☐ Another Patient: _____
- ☐ Other:_____