PATIENT INFORMATION (PLEASE FILL OUT COMPLETELY)

Name: _____ Date of Birth: _____ Sex: ( ) Female ( ) Male

Social Security Number: _____ Marital Status: _____ Preferred Language: _____

E-Mail Address: _____ Nationality (Ethnicity):_____

Race: ( )American Indian or Alaska Native ( )Asian ( )Black or African American ( )Native Hawaiian or other Pacific Islander ( )White ( )Other:_____

Address: _____ City: _____ Zip: _____

Home #: _____ Work #: _____ Cell #:_____

Employer:_____

Preferred Contact Method: ( ) Phone ( ) Mail ( ) Patient Portal Preferred Reminder Method: ( ) Cell ( ) Home ( ) Work ( ) Mail ( ) Patient Portal

Local Pharmacy Name: _____ Cross Streets:_____

Mail Order Pharmacy: _____Which is your primary pharmacy? ( ) Local ( ) Mail Order

How did you hear about our practice? ( ) Family/ Friends ( ) Website ( ) Insurance Co. ( ) Other: _____

Emergency Contact Information (nearest friend or relative)

Name:_____ Relationship:_____

Address: _____ City:_____ Zip:_____

Home #:_____ Work #:_____ Cell #:_____

Emergency Contact Information (nearest friend or relative NOT living with you)

Name: _____ Relationship: _____

Home #: _____ Work #: _____ Cell #:_____

Please complete if the patient is under 18 yrs of age

Mother's Name: _____ Home #: _____

Address: _____ City: _____ Zip: _____

Mother's Employer: _____ Work #:_____ Cell #:_____

Father's Name: _____ Home #: _____

Address: _____ City: _____ Zip: _____

Father's Employer:_____ Work #:_____ Cell #:_____

Financial Responsibility: Medical services are provided to a person, not to an insurance company thus, the insurance co. is responsible to the patient, and the patient is responsible to Village Family Practice. We cannot render services on the assumption that charges will be paid by an insurance co. However, as a service to you, we will submit your claims to your insurance co. You are responsible for any deductible amount, co-insurance, co-payment or other balance not paid for by your insurance. In order to control billing costs and comply with our insurance contracts, your portion of charges must be paid at the time of service. If you do not have proof of current insurance with you, you will be required to pay in full at the time of service.

Treatment of Children / Minors: I authorize emergency medical treatment for the minor listed above, in the event I cannot be contacted.

Assignment of Benefits: I authorize payment of medical benefits to treating physician for these and all future claims. I further authorize the release of any medical information necessary to process this and all future claims.

_____ _____

Patient Signature or Authorized Agent **Date**