Vineville Internal Medicine

PATIENT INFORMATION:			
Patient's Legal Last Name:	First:	Middle	Marital Status (circle one) ( ) Single ( ) Married ( ) Divorced ( ) Separated ( )Widowed
Email Address:		Race (circle one): ( )American Indian ( ) Alaska Native ( )Asian ( ) Hawaiian ( )Black or African American ( ) White ( ) Hispanic ( ) Other	
Date of Birth:	Sex (Circle One) ( ) Male ( ) Female	Social Security No:	
Street Address:	Cell Phone: ( )	Home Phone: ( )	
City:	State:	Zip Code:	
Occupation:	Employer:	Employer Phone: ( )	

HEALTH INFORMATION DISCLOSURE: List anyone that may call on your behalf or pick up any prescriptions if you are unable to do so			
Name/Phone Number	1. / ( )	2. / ( )	
3. / ( )		4. / ( )	

INSURANCE INFORMATION:			
Name of Primary Insurance:		Subscriber's SSN: (if different from patient)	
Subscriber's Name: (if different from patient)		DOB:	
ID/Policy Number:		Group Number/Plan Code:	
Patient's Relationship to Subscriber: ( ) Child ( ) Self ( ) Spouse ( ) Other			
Name of Secondary Insurance: (if Applicable)		Subscriber's SSN: (if different from patient)	
Subscriber's Name: (if different from patient)		DOB:	
ID/Policy Number:		Group Number/Plan Code:	
Patient's Relationship to Subscriber: ( ) Child ( ) Self ( ) Spouse ( ) Other			
Other Insurance:		ID/Policy Number:	Group Number/Plan Code:

IN CASE OF EMERGENCY:			
Name:	Relationship to Patient:	Cell Number:	Home Number:

The above information is true to the best of my knowledge. I hereby authorize direct payment to my physicians from my insurance company when applicable. I understand that I am responsible for any balance(s) not paid by my insurance carrier and is to be paid to VIM. Said balance is to be paid in a timely manner. I also authorize the release of any medical information to a referring physician or insurance company.

Patient/Guardian Signature: Date: