www.vwfw.com - (480) 782-0993 – (855) FAX-VWFW

PATIENT INFORMATION RECORD

Please Print

Patient Name ______________________________ Age __________ Gender □M □F
Last First Middle Initial

Home Phone ______________ Cell Phone ______________ DOB ______________ SSN ______________

Email Address ______________________________ Marital Status □S □M □W □D □Sep

Street Address ______________________________
City State Zip

Primary Doctor ______________________________ Phone ______________

Primary Doctor Address ______________________________
City State Zip

Pharmacy ______________ Cross Streets______________ Phone ______________

Pharmacy Address ______________________________
City State Zip

Referred by ______________________________

Emergency Contact ______________________________ Relationship ______________

Street Address ______________________________ Phone ______________
City State Zip

Spouse (or Parent, if minor) ______________________________
Last First Middle Initial

Date of Birth ______________ SSN ______________ Phone ______________

Street Address ______________________________
City State Zip

Primary Insurance Company ______________________________

Street Address ______________________________ Phone ______________
City State Zip

ID# ______________________________ Group# ______________

Policyholder's Name ______________________ Relationship to Patient __________ DOB __________

Policyholder's Address ______________________________ Phone ______________

Policyholder’s Gender □M □F City State Zip

Other Insurance Company ______________________________

Street Address ______________________________ Phone ______________
City State Zip

ID# ______________________________ Group# ______________

Policyholder's Name ______________________ Relationship to Patient __________ DOB __________

Policyholder's Address ______________________________ Phone ______________

Policyholder’s Gender □M □F City State Zip

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

______________________________ ______________________________
Responsible Party Signature Date

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