



Full legal name: _____ **Date of Birth:** ___ / ___ / ___
FIRST MIDDLE INITIAL LAST

Preferred name: _____ **Social Security #:** ___ - ___ - ___

Current mailing address:

STREET ADDRESS TOWN STATE ZIP

Permanent/Alternative address (if different than above):

STREET ADDRESS TOWN STATE ZIP

We have your permission to discuss your care/results with _____ Phone: _____

Phone numbers (✓ best place to reach you): **Emergency contact (required):**

Home: _____ Cell: _____ Name: _____

Work: _____ Other: _____ Relationship to you: _____

Phone: _____

If you are using your insurance today:

Please give your insurance card to the person at the front desk. If you choose to bill insurance for which you are not the primary subscriber, the policy holder may receive mail from the insurance company detailing where you received health care and the nature of the care.

Your relationship to the person holding the insurance policy: _____

Insurance Subscriber: _____ **Date of Birth:** ___ / ___ / ___

Please read the following and sign below.

VWC may release any medical information and/or medical records needed by my health insurance company for determining benefits or paying claims. Payments from my health insurance company will be made directly to VWC. I understand that I am responsible to pay any deductibles, co-payments, or co-insurances for services not covered by insurance.

SIGNATURE DATE

FOR OFFICE USE ONLY:

Date _____ Initials _____ Patient # _____

PATIENT INFORMATION FORM