VILLAGE INTERNAL MEDICINE, P.A
1843 Quiet Cove
Fayetteville, North Carolina 28304
(910) 483-8080
Fax: (910) 484-8030

PLEASE PRINT

Doctor (choose one) __Viswanath ___Meeks ___ Chai ____Deeb

Full Name_____ **SS#** _____-_____-_____**DOB** __/__/_____

Street Address_____**City**_____

State_____**Zip**_____**Home phone #** (_____) _____**M**__ **F**__ **Race/Ethnicity** _____

Employer_____ **Employer's Address**_____

Employer Telephone (_____) _____ **Your Occupation**_____**S**__**M**__**D**__ **Widow**_____

Drivers' License #_____**Your Cell Phone #** (_____) _____

Name of responsible party _____**Relationship**_____

SS#_____-_____-_____**DOB**_____/_____/_____**Cell Phone #**_____

Employer Name_____

Employer Address_____

Employer Telephone (_____) _____ **Occupation**_____

Primary Insurance Company_____

Secondary Insurance Company_____

Who is your current physician? _____

Who were your past physicians?_____

Name of Emergency Contact (Not living with you) _____

Telephone Number of Emergency Contact_____**Relationship**_____

Reason for Visit_____

Last Hospitalization_____**Hospital** _____**Reason for Hospitalization**_____

Who referred you to our office_____**?**

Does the Patient have other family members who are also our patients? _____

What is your E-Mail Address? _____

Name and Phone # of your Pharmacy _____

I hereby give authorization to release information to pay benefits to Village Internal Medicine. I hereby assign payment directly to the designated provider for any medical/surgical procedures performed. I agree to be responsible for payment of service determined by my insurance carrier as not medically necessary or non-covered service. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

Photo ID's required for identification purpose only.

_____ _____

Signature of Patient **Date**