

**VILLAGE INTERNAL MEDICINE, P.A**

1843 Quiet Cove

Fayetteville, North Carolina 28304

(910) 483-8080

(910) 483-3258, fax

**PLEASE PRINT**

Doctor (choose one) \_\_\_Viswanath \_\_\_Meeks \_\_\_ Chai

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 I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.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

