

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 ___ Logue ___ Meeks ___ Solomon

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 I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.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