Virginia Natural Health

Patient Registration Form

Personal Information

Mr./ Mrs./ Ms./ Miss Social Security Number:

Last name: First: Middle:

Birth Date: / / Age: Gender: □ Male □ Female

Street Address/ PO Box:

City: State: Zip Code: E-Mail Address:

Home Phone: ( ) Office Phone: ( ) Cell Phone: ( )

Name and address of person responsible for payment, if different than patient:

Payment is due at time of office visit.

Some patients prefer not to have health-related messages left where others might hear them. Please tell us where we may and may not leave messages that might be sensitive, and initial after your choice. This is a legal release for VNH to leave messages.

You MAY leave messages for me on my (circle those allowed):

Home phone Office phone Cell phone E-mail None, speak only to me in person

Please do NOT leave messages on my:

Home phone Office phone Cell phone E-mail All, speak only to me in person

Please initial here: _____

You may discuss details of my health with:_____

Emergency Contacts

Name of family member to contact: Relationship: Home Phone: ( ) Work Phone: ( )

Friend or relative not at same address: Relationship: Home Phone: ( ) Work Phone: ( )

_____ _____

Patient/Guardian signature Date