



## Patient Information

Last Name	First Name	Middle Initial
Date of Birth	Gender:    Male    Female	
<b>Contact Information</b>		
Mailing Address		
City	State	Zip
Home Phone	Work Phone	Cell Phone
Email		
Emergency Contact	Phone Number	
<b>Insurance information</b>		
Name of Policy Holder (Primary Insurance)		Date of Birth
Insurance Company	Group Number	ID Number
Name of Policy Holder (Secondary Insurance -- if applicable)		Date of Birth
Insurance Company	Group Number	ID Number
Co-Pay Amount    \$	Referrals Required?	YES    NO

Per my signature below, I give Village Family Clinic & Wellness Center and Kristina Garrido, ARNP, permission to bill my insurance for medical services. I understand that I am responsible for any remaining monetary balance and will be billed accordingly.

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Signature of Patient Date