



**Roanoke**  
 1505 Franklin Rd. SW  
 Roanoke, VA 24016  
 T (540) 343-7331  
 F (540) 343-7349

**Lynchburg**  
 2015 Tate Springs Rd.  
 Lynchburg, VA 24501  
 T (434) 846-2244  
 F (434) 846-0602

**Salem**  
 3529 Keagy Rd.  
 Salem, VA 24153  
 T (540) 981-5653  
 F (540) 725-1356

**Patient Information Sheet**

**Account: \_\_\_\_\_**

Patient's Name (Please print and include middle initial)		Sex M F	Marital Status S M W D Sep		Age	Home Phone
Date of Birth	Social Security #	Race/Ethnicity			Cell Phone	
Street Address Apt. Number		City	State	Zip Code	Email Address	
Primary Care Physician		Address			Phone	
Referring Physician		Address			Phone	
Emergency Contact		Address			Phone	

How did you find out about our office?

Friend/Family      Doctor Referral      Radio      Internet Search      Other (Please explain):

**If Patient is an Adult**

Patient's Employer			Work Phone
Spouse's Name	Spouse's Date of Birth	Spouse's Social Security #	Spouse's Cell Phone
Spouse's Employer			Spouse's Work Phone

**If Patient is a Child**

Father's Name	Father's Date of Birth	Father's Social Security #	Father's Cell Phone
Father's Address (If different from patient's)		Employer	Father's Work Phone
Mother's Name	Mother's Date of Birth	Mother's Social Security #	Mother's Cell Phone
Mother's Address (If different from patient's)		Employer	Mother's Work Phone

**Insurance Information**

\*We will only bill Primary and Secondary

Name of Primary Insurance	Policy Holder	Birth Date	Policy or ID #	Group #
Policy Holder's Address (If different from patient's)			Relationship to patient	
Name of Secondary Insurance	Policy Holder	Birth Date	Policy or ID #	Group #
Policy Holder's Address (If different from patient's)			Relationship to patient	

Signature: \_\_\_\_\_ Date: \_\_\_\_\_