Patient Information

VIRGINIA FAMILY
Chiropractic & Physical Medicine

❑ **ALEXANDRIA**
5130 Duke St Suite 114
Alexandria , VA 22304
P: (703) 370-5300
F: (703) 370-0080

❑ **WOODBRIDGE**
14904 Jefferson Davis Hwy. Suite 301
Woodbridge, VA 22191
P: (703) 499-8840
F: (703) 499-8842

❑ **FALLS CHURCH**
7121 G Leesburg Pike, Suite 207
Falls Church, VA 22043
P: (703) 538-3830
F: (703) 538-3831

❑ **MANASSAS**
8420 Dorsey Circle Suite 101
Manassas, VA 20110
P: (703) 367-7878
F: (703) 367-0009

Name: (First,M,Last) _____ ❑ Home Phone: _____

Social Security #: _____ ❑ Work Phone: _____

Current Address: _____ ❑ Cell Phone: _____

City/State/Zip: _____ ❑ Email: _____

Age: _____ **Sex:** ❑ M ❑ F **Martial Status:** ❑ Single ❑ Married ❑ Widowed ❑ Divorced

EMPLOYMENT INFORMATION

Employment Status: ❑ Employed ❑ Part-time Student ❑ Full-time Student Oth- er:

Current Employer: _____ Occupation: _____

Employer's Address: _____

City/State/Zip: _____

SPOUSE INFORMATION

Name: (First,M,Last) _____ Date of Birth: _____

Social Security #: _____ Phone: _____

Current Address: _____ Employer: _____

City/State/Zip: _____ Emp.'s Phone: _____

RELATIVE TO CONTACT IN CASE OF EMERGANCY

Name of Insured: _____ Relationship: _____

Current Address: _____ Phone: _____

City/State/Zip: _____

IS YOUR ILLNESS OR INJURY RELATED TO ANY OF THE FOLLOWING?

❑ Employment ❑ Emergency ❑ Accident ❑ Auto Accident (State of Auto Accident) _____

If employment related, has employer been notified? ❑ Yes ❑ No ❑ Employer contact name: _____

HOW WERE YOU REFERRED TO OUR OFFICE?

❑ Doctor ❑ Patient ❑ Yellow Pages ❑ Attorney ❑ Google ❑ Yelp ❑ Internet ❑ Zoc Doc ❑ 123 Chiropractor ❑ Other

Please print the name of your source: _____

CONSENT TO TREATMENT/FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I voluntarily consent to receive medical and health services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to VA Family Chiropractic all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. The notice of privacy practice has been provided in the office. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I consent that I am allowing VA Family Chiropractic & Physical Medicine (and HS agents) to contact me via mail, email, text and phone in regards (but not limited to) any potential bills, missed appointments, etc.

_____ _____

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE. DATE