



# VIRTUAL MEDICAL PRACTICE, LLC

*expanding genetic horizons...*

## GENERAL CONTACT INFORMATION FORM

### PATIENT INFORMATION:

|   |                       |   |
|---|-----------------------|---|
| PATIENT NAME<br>Last First Middle Initial   | Date of Birth         | Gender<br>Female <input type="checkbox"/> Male <input type="checkbox"/> |
| STREET APT  | PRIMARY EMAIL ADDRESS |   |
| CITY STATE ZIP  | PRIMARY PHONE NUMBER  |   |
| If not supplying an enlarged copy of front/back of Ins card, please provide Insurance including Group # and Member #. Note: we do not submit ins claims but the forms we supply you need this info. |                       |   |

### PARENT/SPOUSE INFORMATION:

|   |   |   |                                       |  |               |
|---|---|---|---------------------------------------|--|---------------|
| MARITAL STATUS of patient or parents<br>SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | WHO IS FILLING OUT THIS FORM?<br>Mother/Wife <input type="checkbox"/> Father/Husband <input type="checkbox"/> Guardian <input type="checkbox"/> |                                       | WHO SHOULD BE PRIMARY CONTACT?<br>Mother/Wife <input type="checkbox"/> Father/Husband <input type="checkbox"/> Guardian <input type="checkbox"/> |               |
| MOTHER/WIFE LAST, FIRST NAME  |   | Date of Birth   | FATHER/HUSBAND LAST, FIRST NAME       |  | Date of Birth |
| ADDRESS (IF DIFFERENT FROM PATIENT'S)   |   |   | ADDRESS (IF DIFFERENT FROM PATIENT'S) |  |               |
| EMAIL (IF DIFFERENT FROM PATIENT'S)   |   |   | EMAIL (IF DIFFERENT FROM PATIENT'S)   |  |               |
| HOME PHONE  | CELL  |   | HOME PHONE                            | CELL   |               |
| BUSINESS PHONE  | WHICH PHONE SHOULD WE TRY 1 <sup>st</sup> ? |   | BUSINESS PHONE                        | WHICH PHONE SHOULD WE TRY 1 <sup>st</sup> ?  |               |

### REFERRING PHYSICIAN & PHYSICIANS WHO SHOULD RECEIVE COPY OF OUR NOTES – use another sheet if necessary

|                            |                     |                   |
|----------------------------|---------------------|-------------------|
| 1) REFERRING PRACTICE NAME | WEBSITE OF PRACTICE |                   |
| Referring Doctor's Name    | PHONE #             | FAX # (important) |
| 2) PRACTICE NAME           | WEBSITE OF PRACTICE |                   |
| DOCTOR'S NAME              | PHONE #             | FAX # (important) |
| 3) PRACTICE NAME           | WEBSITE OF PRACTICE |                   |
| DOCTOR'S NAME              | PHONE #             | FAX # (important) |

### PREFERRED PHARMACY

|   |                      |         |
|---|----------------------|---------|
| PHARMACY NAME & STREET ADDRESS, CITY, STATE | ZIP CODE (important) | PHONE # |
|---|----------------------|---------|

### EMERGENCY CONTACT – residing at a different address (i.e. friend, relative):

|            |              |
|------------|--------------|
| LAST FIRST | PHONE NUMBER |
|------------|--------------|