VIRGINIA INSTITUTE
OF FAMILY MEDICINE

Patient Demographic Intake Form

Patient Information

Patient Name:

Date of Birth:

Address:

Telephone Number:

Email Address:

Emergency Contact Information

Emergency Contact Name:

Emergency Contact Phone:

Emergency Contact Email:

Insurance Information

Insurance Company:

Member ID Number:

Group Number:

Preferred Pharmacy

Pharmacy Name & Location:

Pharmacy Phone Number:

Communication Preferences

Do you agree to receive text messages from our practice? ☐ Yes ☐ No

Do you agree to receive email communication from our practice? ☐ Yes ☐ No