

# VistaFamilyHealth

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Today's Date: \_\_\_\_\_

## ***Patient (person being seen today):***

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Gender:  Male  Female  
Marital Status:  Single  Married  Divorced  
 Widowed  Other \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home #: ( ) \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ ext \_\_\_\_\_

Cell#: ( ) \_\_\_\_\_

Employment Status:  Full Time  Part Time  Self Employed  Retired  Not Employed  
Student Status:  Full Time  Part Time  Not a Student  
School: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

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## ***If Patient is a Minor Child (less than 18 years old) please complete the following:***

Patient lives with:  Father  Step-Father  
 Mother  Step-Mother  
 Both Parents  Other: \_\_\_\_\_

*(Please continue on other side/Two Sided Document)*

**Complete the following if patient is a minor child (under 18yrs old)**

***Father/Guardian***

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home #: ( ) \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ ext \_\_\_\_\_

Cell#: ( ) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

***Mother/Guardian***

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home #: ( ) \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ ext \_\_\_\_\_

Cell#: ( ) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

**Insurance- Please provide copy to receptionist**

Primary: \_\_\_\_\_ Effective Date: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
(Include Alpha Pre-fix if applicable)Insurance Address: \_\_\_\_\_  
Street or PO Box. City State Zip**Policy Holder**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_

ID # (if different from patient's) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
(Must have to bill insurance)

Employer: \_\_\_\_\_ Employer phone #: ( ) \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street City State ZipPatient's relationship to policy holder:  Self  Wife  Other \_\_\_\_\_  
 Husband  Child

Secondary: \_\_\_\_\_ Effective Date: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
(Include Alpha Pre-fix if applicable)Insurance Address: \_\_\_\_\_  
Street or PO Box. City State Zip**Policy Holder**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_

ID # (if different from patient's) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
(Must have to bill Insurance)

Employer: \_\_\_\_\_ Employer phone #: ( ) \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street City State ZipPatient's relationship to policy holder:  Self  Wife  Other \_\_\_\_\_  
 Husband  ChildDo you have additional Insurance Coverage?  Yes  No, if you answered yes, please ask the receptionist for an additional form.***(Please continue on other side/Two Sided Document)***

