Falls Church Healthcare Center
900 South Washington Street, Suite 300 Falls Church, VA 22046 (703) 532-2500

We may need to inform you of important medical information, reminders or rescheduling issues. To assist us please fill this form **completely** with accurate information so our doctor or staff can contact you when necessary**.**
If you are using your insurance, we will need to make a copy of your photo ID for your chart.

NAME: _____ DATE OF BIRTH: _____ AGE: _____

CURRENT ADDRESS: _____
Street

_____
City State Zip

HOME PHONE: _____ May we leave a message there? ☐ Yes ☐ No

WORK OR CELL PHONE: _____ May we leave a message there? ☐ Yes ☐ No

This Information for Division of Vital Records, Virginia Department of Health is submitted without your identifying information: PLEASE Check all that applies.

COUNTY OF RESIDENCE: ☐ Fairfax ☐ Arlington ☐ Loudoun ☐ Prince William Other _____

HIGHEST GRADE LEVEL COMPLETED:_____ **STATUS**: ☐ MARRIED ☐ SINGLE

RACE: ☐ AM. INDIAN ☐ BLACK/AFRICAN AMERICAN ☐ WHITE ☐ MIXED (PLEASE LIST ALL)_____

☐ ASIAN COUNTRY OF ORIGIN _____

ETHNIC ORIGIN: HISPANIC COUNTRY OF ORIGIN _____ OTHER _____

PERMISSION TO RELEASE INFORMATION: □ FCHC can mail normal lab result card and/or my appointment reminder to above address.
FCHC CAN ALSO LEAVE MESSAGE/ INFORMATION WITH: □ Name: _____Relationship_____ Phone:_____
STAFF BOYT: TODAY'S DATE: _____