



Vital Well-Being Center, Inc.

210 S. Pinellas Ave., Suite 106
Tarpon Springs, FL 34689

727-786-1661 Office
727-785-3783 Fax

Patient Questionnaire

Payment of fees is due at time of service- Temporary checks are not accepted

Please PRINT

Patient's Name _____

Permanent Address: _____ City _____ State _____ Zip _____

Florida Address: _____ City _____ State _____ Zip _____

Permanent Phone: (____) _____ - _____ Florida Phone: (____) _____ - _____

Date of Birth: ____/____/____ Age: _____ Sex: _____ Marital Status: _____

Social Security Number: _____ - _____ - _____ Medicare Number: _____ - _____ - _____

Employer: _____ Employer Phone: (____) _____ - _____

Employer Address: _____ Email Address: _____

Drivers License Number: _____ State: _____

Referred By: _____ Friend _____ Doctor _____ Other _____

If patient is under the age of 18, parent or legal guardian must complete the following

Name: _____ Social Security Number: _____ - _____ - _____

Permanent Address: _____ City _____ State _____ Zip _____

Florida Address: _____ City _____ State _____ Zip _____

Permanent Phone: (____) _____ - _____ Florida Phone: (____) _____ - _____

Employer: _____ Employer Phone: (____) _____ - _____

Employer Address: _____

Driver's License Number: _____ State: _____

The undersigned patient or responsible party acknowledges that medical services will be rendered in exchange for payment.

**** I authorize the release of medical records necessary to process my insurance claim.***

Signature: _____ Date: ____/____/____

Circle method of payment: Cash Check Debit Card Visa Mastercard Discover