FAIRVIEW

TRUSTED FOR GENERATIONS

Outpatient Patient Intake Form

PATIENT INFORMATION

Name: ______________________________ Date: ______________________

Address: ____

City: ____________________ State: ______________ Zip: ______________

Date of Birth: ______________________ SSN: ______________________

Daytime phone: ____________________ Evening phone: ____________________

Cell phone: ____

Email: ____

Occupation: ____

PRIMARY CARE PHYSICAN (PCP)

PCP Name: ____

Location / Hospital: ____

Phone number: ____

EMERGENCY CONTACT

Name: ____

Relationship to Patient: ____

Phone Number: ____

INSURANCE INFORMATION

Insurance Company: ____

Name of the Insured: ____

Relationship to Patient: ____

Patient ID number: ____________________ Group ID number: ____________________

Secondary Insurance Company: _____________________________________

Name of the Insured: ____

Relationship to Patient: ____

Patient ID number: ____________________ Group ID number: ____________________

Patient Signature: ______________________________ Date: ____________________