PATIENT INFORMATION INTAKE FORM FOR AFC PATIENTS

PATIENT INFORMATION

FIRST NAME		DATE OF BIRTH	
MIDDLE NAME		SOCIAL SECURITY #	
LAST NAME		GENDER	
PREFERRED NAME		MARITAL STATUS	
		SPOUSE'S FIRST NAME	
		SPOUSE'S LAST NAME	
		SPOUSE'S DATE OF BIRTH	

PERSON RESPONSIBLE FOR MEDICAL BILLS AND ADDRESS OF WHERE TO SEND THEM

FIRST NAME		STREET ADDRESS	
MIDDLE INITIAL		APT OR LOT NUMBER	
LAST NAME		CITY	
RELATIONSHIP TO PATIENT		STATE	
HOME PHONE		ZIP CODE +4	
CELL PHONE		WORK PHONE	

EMERGENCY CONTACT INFORMATION

FIRST NAME	
LAST NAME	
RELATIONSHIP TO PATIENT	
HOME PHONE	
CELL PHONE	
WORK PHONE	

PREVIOUS PHYSICIAN INFORMATION

FIRST NAME	
LAST NAME	
STREET ADDRESS	
CITY & STATE	
ZIP CODE	
PHONE NUMBER	

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE		STREET OR PO BOX	
CONTRACT/POLICY NUMBER		CITY, STATE	
GROUP NUMBER		ZIP CODE +4	
		PHONE NUMBER	

NAME OF SECONDARY INSURANCE		STREET OR PO BOX	
CONTRACT/POLICY NUMBER		CITY, STATE	
GROUP NUMBER		ZIP CODE +4	
		PHONE NUMBER	

NAME OF TERTIARY INSURANCE		STREET OR PO BOX	
CONTRACT/POLICY NUMBER		CITY, STATE	
GROUP NUMBER		ZIP CODE +4	
		PHONE NUMBER	

NAME OF PHARMACY INSURANCE		STREET OR PO BOX	
CONTRACT/POLICY NUMBER		CITY, STATE	
GROUP NUMBER		ZIP CODE +4	
		PHONE NUMBER	

PLEASE INCLUDE COPIES OF ALL INSURANCE CARDS (FRONT AND BACK SIDES)

Revised 05/08/12 cmf