2003 Kootenai Health Way
Coeur d'Alene, ID 83814
PH: 208.625.4000
Kootenaihealth.org

PATIENT INTAKE

Last Name: _____ **First Name**: _____ **MI**: _____

Date of birth: _____ **Social Security #:** _____

Physical address: _____ City: _____ State: _____ Zip: _____

Mailing address (if different): _____ City: _____ State: _____ Zip: _____

Phone: _____ Alternate phone number: _____

Email Address: _____ @ _____

Primary Emergency Contact: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Relationship: _____

Secondary Emergency Contact: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Relationship: _____

If Patient is a Minor: (Please list person signing consent to treat)

Parent/Guardian name: _____ Relationship: _____

Parent/Guardian SS#: _____ Parent/Guardian DOB: _____

Address if different then patient: _____

Parent/Guardian Employer: _____ Employer Address: _____

City: _____ State: _____ Zip: _____

Insurance Information:

Primary Insurance: _____

Policy number: _____

Group number: _____

Subscriber name: _____

Relationship: _____

Date of birth: _____

Social security number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Secondary Insurance: _____

Policy number: _____

Group number: _____

Subscriber name: _____

Relationship: _____

Date of birth: _____

Social security number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Primary Care Provider: _____ **Phone Number**: _____

KootenaiHealth

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Are you being seen because of an accident? ☐ No ☐ Yes, if yes, was accident employment related? ☐ No ☐ Yes

Date of Accident:_____ **Time:**_____ **Nature of Injury:**_____

State Accident Happened:_____ **Location of Accident:**_____

Do you have an advanced directive/living will? ☐ Yes ☐ No

Are you employed? ☐ Yes ☐ No

Name of employer:_____ Phone:_____

Address: _____ City:_____ State:_____ Zip:_____

Marital Status: ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Single

What is your race? (Check all that apply):

☐ American Indian or Alaska Native ☐ Asian ☐ African American

☐ Native Hawaiian or other Pacific Islander ☐ White/Caucasian ☐ Other ☐ Refuse to answer

Do you have a religious preference? ☐ No ☐ Yes, if yes please list: _____

What is your preferred language:_____ **Do you request an interprete**r: ☐ Yes ☐ N

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refuse to answer

This section is to be filled out only by patients transferring from another facility.

Directory Disclosure: I hereby request that my name, general condition, religious affiliation, and location not be included in the hospital directory. By invoking this right, I understand that people inquiring by telephone and visitors will be told "I have no information about this patient". No deliveries, including flowers will be forwarded to me.

☐ Yes, I wish to have my name removed from the hospital directory and be made confidential.

_____ _____

Printed Name Relationship to Patient

_____ _____ / _____

Signature of Patient/Legal Guardian/Power of Attorney Date Time