Kootenai Clinic: New Patient Information Form

Patient Information

Today's Date:_____/_____/_____

Primary Care Physician:_____

Referred By:_____

Last Name:_____ First Name_____ Middle Name:_____

Previous Last Name:_____ Birthdate:_____/_____/_____

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

Home Phone: (_____)_____-_____ Cell Phone: (____)_____-_____ Work Phone: (____)_____-_____Ext_____

E-Mail Address: _____

Gender: ☐ Male ☐ Female ☐ Transgender Marital Status: ☐ Single ☐ Married ☐ Partner

☐ Separated ☐ Divorced ☐ Widowed

Address if different from Mailing Address:

Street Address:_____ City:_____State: _____Zip: _____

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American Preferred Language_____

☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

☐ Hispanic ☐ Prefer not to disclose

Hearing Impaired ☐ Yes ☐ No

Ethnicity: ☐ Hispanic/Latin ☐ Non-Hispanic Latin ☐ Prefer not to disclose Vision Impaired ☐ Yes ☐ No

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Employer Information

Employer Name:_____Phone: (_____) _____-_____

Employment Status:

☐ Full Time ☐ Part Time ☐ Retired ☐ Self Employed ☐ Unemployed ☐ Active Military ☐ Veteran ☐ Student

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Emergency Contact

Last Name:_____First Last Name:_____ Relation:_____

Street Address:_____City:_____State:____Zip:_____

Contact Number: (_____) _____-_____ ☐Home ☐Work Ext:_____

☐ Individual is legal guardian ☐ Individual is caregiver

Patient Identification – Write in or attach patient label

Name:

MRN #:

CSN #:

Age/Sex:

KootenaiClinic

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Name: _____
DOB: _____
Date: _____

Guarantor Information (person responsible for payment)

Last Name:_____First Name:_____Relation:_____Ph (_____)_____-_____

Address:_____City:_____State:_____Zip_____

Birthdate: _____Employer:_____Employer Phone: (_____)_____-_____

Insurance Information *Self Pay (No Insurance)* ☐

Primary Insurance:_____ Secondary Insurance_____

Insurance ID _____ Group Number:_____

Subscriber:_____Relation_____ Subscriber:_____Relation:_____

Subscriber address: _____ Subscriber address: _____

Birthdate: _____ Birthdate: _____

Industrial Information for Work Injuries:

Date of Injury: ____/____/_____ State Injured In:_____ Employer Name:_____

Industrial Insurance Co.:_____Claim #_____Claim Mgr Name_____

Industrial Address:_____Claim Mgr Phone: (____)_____-_____

Industrial Phone: (_____) _____-_____ Fax (_____) _____-_____ Claim Mgr Fax: (____)_____-_____

Do you have any advance directives? (Living will, Durable Power of Attorney) ☐ Yes ☐ No

If yes, please provide a copy of all available directives to the Front Desk.

Please refer to your new patient packet for more information on advance directives.

Thank you!

Patient signature _____

Print name of person filling out the form (if not the patient) _____

If employee, list your title _____

Patient Identification – Write in or attach patient label

Name:
MRN #:
CSN #:
Age/Sex: