FAIRBANKS PSYCHIATRIC & NEUROLOGICAL CLINIC, P.C.
1919 Lathrop Street, Suite 220, Fairbanks, AK, 99701 Phone: (907) 452-1739 Fax: (907) 452-2384

Intake Form: Demographics and Insurance

Patient Information	Chart # (Office Use Only)	Account # (Office Use Only)
Legal Name (Last, First, Middle)		

Sex M ◯ F ◯	Date of Birth	Age	Social Security No.
Mailing Address			

City	State	Zip Code
Primary Contact Number	Secondary Contact Number	
Emergency Contact's Name	Emergency Contact's Number	

Patient's Supplementary Information		
Preferred Name	Pronouns ☐he ☐she ☐they ☐Other:_____	
Marital Status	Primary Care Provider	Referring Provider
Employer (if student, indicate school)	Occupation	

Required even when cards are scanned.

Primary Insurance	Policy #/ID #/etc.	Group # (if applicable)
Policy Holder's Name	Self ☐ (Skip rest of section)	Holder's Phone Number
Holder's D.O.B.	Holder's SSN	Holder's Relation to Patient
Secondary Insurance	Policy #/ID #/etc.	Group # (if applicable)
Policy Holder's Name	Self ☐ (Skip rest of section)	Holder's Phone Number
Holder's D.O.B.	Holder's SSN	Holder's Relation to Patient
Tertiary Insurance	Policy #/ID #/etc.	Group # (if applicable)
Policy Holder's Name	Self ☐ (Skip rest of section)	Holder's Phone Number
Holder's D.O.B.	Holder's SSN	Holder's Relation to Patient

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Patient's/Guardian's Initials: _____

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Intake Form: Guardianship and Other Insurance

Legal Guardian Information (if applicable)			
Name (Last, First, Middle)	D.O.B.	Social Security No.	
Mailing Address			
City	State	Zip Code	Relation to Patient
Primary Contact Number	Secondary Contact Number		

If the patient is under guardianship despite being 18 or older, a copy of the guardianship paperwork **must** be presented at intake. If the patient has multiple legal guardians, the individual listed in this section **must** be the one to sign the intake paperwork.

Does the patient have Workers' Compensation Coverage? **YES** ○ **NO** ○	
Name of Company	Date of Accident or Injury
Claim Number	Policy Holder's Phone Number

Does the patient have Motor Vehicle Accident Coverage? **YES** ○ **NO** ○		
Name of Company	Date of Accident or Injury	
Claim Number	Policy Holder's Phone Number	
If Motor Vehicle Accident: Information of Liable Party		
Legal Name (Last, First, Middle)	Phone Number	
Mailing Address		
City	State	Zip

I, the undersigned, affirm the above information is accurate as of the date this document is signed. I acknowledge I am responsible for updating this Clinic in a timely manner of changes to information above. I acknowledge full responsibility for the payment of services regardless of insurance coverage.

Patient's/Guardian's Signature: _____

Date: _____