FAIRWAY MEDICAL CENTER

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____
FIRST MIDDLE INITIAL LAST MONTH/DAY/YEAR

SOCIAL SECURITY #: _____ MARITAL STATUS: M S W D

DRIVER'S LICENSE #: _____ SPOUSE NAME: _____

PATIENT ADDRESS: _____ HOME PHONE: _____

CITY STATE ZIP: _____ CELL PHONE: _____

EMPLOYED BY: _____ WORK PHONE: _____

EMPLOYER ADDRESS: _____

_____

INSURANCE INFORMATION

PRIMARY INSURANCE:

POLICY HOLDER: ☐ SELF ☐ SPOUSE ☐ PARENT

POLICY HOLDER INFORMATION (IF OTHER THAN SELF):

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ SOCIAL SEC #: _____

_____ HOME PHONE: _____

EMPLOYER: _____

_____ WORK PHONE: _____

INSURANCE COMPANY: _____

MEMBER ID# (POLICY#): _____ **GROUP #:**_____

SECONDARY INSURANCE:

POLICY HOLDER: ☐ SELF ☐ SPOUSE ☐ PARENT

POLICY HOLDER INFORMATION (IF OTHER THAN SELF):

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ SOCIAL SEC #: _____

_____ HOME PHONE: _____

EMPLOYER: _____

_____ WORK PHONE: _____

INSURANCE COMPANY: _____

MEMBER ID# (POLICY#): _____ **GROUP #:**_____

PLEASE PROVIDE RECEPTIONIST WITH YOUR DRIVER'S LICENSE AND INSURANCE CARD(S) FOR COPYING.

THANK YOU.