Patient Intake Form

2800 Main Ave
Fargo, ND 58103
Phone: 701-365-8868 Fax: 7018-365-8870
Web: www.tntkidsfitness.org
Email: leslie@tntkidsfitness.com

Date: _____

Patient Last Name: _____ First Name: _____ Middle Initial:___

Date of Birth: ____/____/_____ Male / Female (circle)

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

Email Address (for billing purposes only): _____

Primary Medical Provider: _____ Facility/Town: _____

Parent Name: Mom _____ Dad _____Other _____

Phone Number: Mom _____ Dad _____ Other _____

Has your child been seen at another facility within the last 12 months? Yes / No (circle)

If yes, where and when? _____

Primary Insurance: _____ Subscriber/Relationship: _____

Policy Number: _____ Group Number: _____ Subscriber Date of Birth: ___/____/____

Secondary Insurance: _____ Subscriber/Relationship: _____

Policy Number: _____ Group Number: _____ Subscriber Date of Birth: ___/____/____

Do you have questions regarding what your insurance will cover and what your financial responsibility will be for services? If yes, our business office will call you. Yes / No (circle)

How did you hear about us? _____ Staff: _____ Date: _____

Other Information: