



New Passenger Intake Form

Date: _____

Patient Name: _____ **DOB:** _____ **Weight:** _____

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

Medical Condition: _____ **Medical Equipment:** _____

Phone(s):

(H): _____ **(W):** _____ **(C):** _____

Person Calling: _____ **Phone:** _____

How did you hear about AFE?: _____

EMAIL ADDRESS: _____

Originating City: _____ **Airport Code:** _____

Destination City: _____ **Airport Code:** _____

Appointment Date & Time: _____

Departure Date : _____ **Return Date:** _____

Patient Phone at Destination: _____ **Lodging:** _____

Passenger Name	Relation	Weight	DOB

****Baggage Weight:** _____ **(40 Lbs. max)**

DOCTORS

Referring:

Name: _____
Facility: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____
Fax: _____

Destination:

Name: _____
Facility: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____
Fax: _____

Social Worker: _____ **Facility:** _____

Address: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **Pager:** _____

EMAIL: _____