

HomeCare Physicians
Date of Intake: _____

Demographic Intake Form
Account # _____

HCP MD: _____
1st Visit Date: _____

*****PATIENT INFORMATION*****

Name: _____
Street: _____
Facility/Complex: _____ Room # _____
Town/State/Zip: _____
HomePhone: _____

Date of Birth: _____ / _____ / _____

Sex: M F

Soc Sec Number: _____ -- _____ -- _____

Marital Status: Married Widow(er) Divorced Single

Lives Alone: **Yes or No**

Lives With: _____

*****EMERGENCY CONTACT INFORMATION*****

Name: _____
Phone: _____
Relationship to Patient: _____
Contact you with Visits/times/etc: **Yes or No**

Name: _____
Phone: _____
Relationship to Patient: _____
Contact you with Visit/times/etc.: **Yes or No**

*****RESPONSIBLE PARTY INFORMATION (Billing Address)*****

Name: _____
Street: _____
Town/State/Zip: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Relationship to Patient: _____

*****PRIMARY INSURANCE*****

Insurance Company: _____
Claim Address: _____
City ST Zip: _____
Group Number: _____
Policy / ID Number: _____
Name on Card: _____
Date of Birth: _____
Soc Sec Number: _____

*****SECONDARY INSURANCE*****

Insurance Company: _____
Claim Address: _____
City ST Zip: _____
Group Number: _____
Policy / ID Number: _____
Name on Card: _____
Date of Birth: _____
Soc Sec Number: _____

*****PRIMARY PHYSICIAN*****

Name: _____
Phone: _____
Fax: _____

*****OTHER INFO*****

How did you hear about us?

Do you have Home Health?
Agency: _____
Phone: _____

Who is calling in referral?
Name: _____