INTAKE FORM

General

Referring Person: _____ Date: _____ Order/PreAuth: _____

Source of Business: _____ Ordered By: _____

Beneficiary Information

Customer ID: _____ Customer/Patient Last Name: _____

First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____ Home Phone: _____ Height: _____

Work Phone: _____ Ext: _____ Weight: _____

Date of Birth: _____ Social Security No: _____ Gender: _____

Email Address: _____

Emergency Contact1: _____ Phone1: _____ Phone2: _____

Relationship: _____ If Others, please describe: _____

Address: _____ State: _____

City: _____ Zip: _____

Emergency Contact2: _____ Phone1: _____ Phone2: _____

Relationship: _____ If Others, please describe: _____

Address: _____ State: _____

City: _____ Zip: _____

Does anyone have Power of Attorney over you? _____

If Yes, who? Name: _____ For Medical? _____

Address: _____ State: _____ Phone1: _____

City: _____ Zip: _____ Phone2: _____

Relationship: _____ If Others, please describe: _____

List the patient's medical condition(s):

_____

Have you discussed this equipment with your doctor? _____

Have you received the same or similiar supplies/equipment before? _____

If Yes, please describe:

_____

Place of Service: _____

Infectious Condition? _____

Medication Profile: _____

Allergies and/or sensitivities: _____

Physician Information:

Ordering Physician: _____ UPIN: _____ NPI: _____

Phone: _____ Fax: _____ State ID 1: _____ State ID 2: _____

Address: _____ State: _____

City: _____ Zip: _____

Secondary Physician: _____ UPIN: _____ NPI: _____

Phone: _____ Fax: _____ State ID 1: _____ State ID 2: _____

Address: _____ State: _____

City: _____ Zip: _____

Diagnosis:

Insurance Information:

Primary Insurance: _____ ID#: _____ Group ID: _____

Address1: _____ Address2: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____

Policy Holder Name: _____ Date of Birth: _____

Patient Relationship: _____ If Others, please describe: _____

Address1: _____ Address2: _____

City: _____ State: _____ Zip: _____

County: _____ Phone: _____ Social Security#: _____

Employer: _____ Work Phone: _____ Ext: _____

Secondary Insurance: _____ ID#: _____ Group ID: _____

Address1: _____ Address2: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____

Policy Holder Name: _____ Date of Birth: _____

Patient Relationship: _____ If Others, please describe: _____

Address1: _____ Address2: _____

City: _____ State: _____ Zip: _____

County: _____ Phone: _____ Social Security#: _____

Employer: _____ Work Phone: _____ Ext: _____

Bill To:

Last Name:				First Name:	
Address1:				Address2:	
City:		State:		Zip:	
County:		Phone:			

Customer Signature: _____

(If required)