HomeCare Physicians | Demographic Intake Form | HCP MD:____________
Date of Intake:_____________ | Account #_______________ | 1st Visit Date:___________

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

Name: ______________________________
Street: ______________________________
Facility/Complex: ____________________ Room # ______
Town/State/Zip: ______________________________
HomePhone: ______________________________
____
____

Date of Birth: _________ / ________ / ________

Sex: M F

Soc Sec Number: _______ -- _________ -- ___________
(as required for billing)

Marital Status: Married Widow(er) Divorced Single

Ethnicity (circle one): Hispanic Non- Hispanic

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: ______________________________