Home Care Physicians
Date of Intake: _____

Demographic Intake Form
Account # _____

HCP MD: _____
1st Visit Date: _____

****PATIENT INFORMATION****

Name: _____
Street: _____
Facility/Complex: _____
Rm # _____
Town/State/Zip: _____
_____
_____

Date of Birth _____/_____/_____

Sex: M F

Soc Sec Number: _____-_____-_____

Marital Status:
Married Widow(er) Divorced Single

Ethnicity (circle one): Hispanic Non-Hispanic

Lives Alone: Yes or No

Contact for Visit/Times **(please specify only 1 person)**
Name: _____
Phone: _____
Relationship to Patient: _____

Does patient have a POA (power of attorney)?
Name: _____
Relationship to Patient: _____

****EMERGENCY CONTACT INFORMATION****
Name: _____
Phone: _____
Relationship to Patient: _____

****RESPONSIBLE PARTY/ GUARANTOR INFO****
Name: _____
Street: _____
Town/State/Zip: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Relationship to Patient _____

****PRIMARY INSURANCE****
Insurance Company: _____
Claim Address: _____
City/State/Zip: _____
Group Number: _____
Policy/ID Number: _____
Name on Card: _____
Date of Birth: _____
Social Security #: _____

****SECONDARY INSURANCE****
Insurance Company: _____
Claim Address: _____
City/State/Zip: _____
Group Number: _____
Policy/ ID Number: _____
Name on Card: _____
Date of Birth: _____
Social Security #: _____

Medicare ID# : _____

CURRENT PRIMARY CARE PHYSICIAN*
Name: _____
Address:
_____
_____
Phone: _____
Fax: _____

****OTHER INFO****
How did you hear about us?
_____

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

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