PROCARE HOME MEDICAL

PATIENT INTAKE

To Be Completed By Patient/ Caregiver

PATIENT: _____ **DOB:** _____ **SS#:** _____

_____
CLIENT'S PHYSICAL ADDRESS **CITY/STATE** **ZIP CODE**

_____
CLIENT'S BILLING/MAILING ADDRESS (IF DIFFERENT THAN PHYSICAL)

_____ _____ _____
HOME PHONE **MOBILE PHONE** **EMPLOYER / WORK PHONE**

_____
CLIENT'S EMAIL ADDRESS

_____ _____
REFERRING MD **PRIMARY MD**

_____ _____ _____
PRIMARY INSURANCE / INSURED NAME **ID # / GROUP #** **DOB**

_____ _____
INSURANCE ADDRESS **INSURANCE PHONE #**

_____ _____ _____
SECONDARY INSURANCE / INSURED NAME **ID # / GROUP #** **DOB**

_____ _____
INSURANCE ADDRESS **INSURANCE PHONE #**

_____ _____ _____
TERITARY INSURANCE / INSURED NAME **ID # / GROUP #** **DOB**

_____ _____
INSURANCE ADDRESS **INSURANCE PHONE #**

RESPONSIBLE PARTY FOR MINOR / INFORMATION

_____
MOTHER'S NAME **SS #** **DOB**

_____
FATHER'S NAME **SS#** **DOB**

EMERGENCY CONTACT INFORMATION – MANDATORY

_____
NAME **PHONE** **RELATIONSHIP**

_____
NAME **PHONE** **RELATIONSHIP**