# NEW PATIENT INTAKE FORM Fax: 866●578●5925

**PATIENT NAME** *(LAST)*: ______ *(FIRST)*: ______ *(MI)*: ______

**ADDRESS**: ______ **APT / BLDG #**: ______

❑ *HOME* ❑ *APARTMENT* ❑ *DOMICILIARY* **NAME OF FACILITY / APT**: ______

**CITY**: ______ **STATE**: ______ **ZIP**: ______ - ______

**PATIENT PHONE**: ______ **IS THIS THE NUMBER TO CALL WHEN MAKING APPTS**: ❑ *YES* ❑ *NO*

**SSN**: ______ **DATE OF BIRTH**: ______ **GENDER**: ❑ *MALE* ❑ *FEMALE*

**MARITAL STATUS**: ❑ *SINGLE* ❑ *MARRIED* ❑ *WIDOWED* ❑ *DIVORCED* **NAME OF SPOUSE**: ______

**IN THE EVENT OF AN EMERGENCY CONTACT**: ______

**RELATION TO PATIENT**: ______ **PHONE**: ______

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**DOES THE PATIENT HAVE A POA / GUARDIAN**: ❑ *YES* ❑ *NO (SKIP THIS SECTION)* **LEGAL STATUS**: ❑ *POA* ❑ *GUARDIAN*

**NAME**: ______ **RELATIONSHIP**: ______

**ADDRESS**: ______ **APT / BLDG #**: ______

**CITY**: ______ **STATE**: ______ **ZIP**: ______ - ______

**POA / GUARDIAN PHONE**: ______ **NOTIFY BEFORE EACH VISIT**: ❑ *YES* ❑ *NO*

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**PATIENT DX / HEALTH ISSUES**: ______

**SPECIAL VISIT INSTRUCTIONS**: ______

**IS THE PATIENT LATEX SENSITIVE**: ❑ *YES* ❑ *NO* **IS THE PATIENT CURRENTLY BEING TREATED BY A PRIMARY PHYS**: ❑ *YES* ❑ *NO*

**IS THE PATIENT CURRENTLY ON OR RECEIVING**: ❑ *HOSPICE* ❑ *HOME CARE* ❑ *AIDE SERVICES* ❑ **OTHER**: ______

**NAME OF AGENCY PROVIDING SERVICES**: ______ **PHONE**: ______

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**HOW DID THE PATIENT HEAR ABOUT OUR SERVICES**: ❑ *WORD OF MOUTH* ❑ *HHA* ❑ *AFC/ALF* ❑ *MARKETING* ❑ *OTHER*

**REFERRING PARTY**: ______ **PHONE**: ______

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**MEDICARE**: ______ **EFFECTIVE DATE**: ______ **HMO INVOLVEMENT**: ❑ *YES* ❑ *NO*

**PART B ELIGIBLE**: ❑ *YES* ❑ *NO* **OPEN MSP** : ❑ *YES* ❑ *NO* **VERIFICATION**: ❑ *C-SNAP* ❑ *PHONE*

**MEDICAID** *(IF APPLICABLE)*: ______ **EFFECTIVE DATE**: ______ **HMO INVOLVEMENT**: ❑ *YES* ❑ *NO*

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**OTHER INSURANCE CARRIER** *(IF APPLICABLE)*: ______

**POLICY NUMBER**: ______ **GROUP NUMBER**: ______

**TYPE OF POLICY**: ❑ *HMO* ❑ *PPO* ❑ *TRADITIONAL* ❑ *PFFS* **PHONE**: ______

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***IN-OFFICE USE ONLY***

**WAS THE PATIENT CORRECTLY NOTIFIED OF POSSIBLE CO-PAYS / INSURANCE COVERAGE**: ❑ *YES* ❑ *NO*

**DATE OF INTAKE**: ______ **EMPLOYEE COMPLETING INTAKE**: ______

**ASSIGNED PHYSICIAN**: ______ **FIRST VISIT DATE**: ______

**ACCOUNT NUMBER**: ______ **MAPCODE** *(IF APPLICABLE)*: ______