

HomeCare Physicians  
Date of Intake: \_\_\_\_\_

Demographic Intake Form  
Account # \_\_\_\_\_

HCP MD: \_\_\_\_\_  
1st Visit Date: \_\_\_\_\_

**\*\*\*PATIENT INFORMATION\*\*\***

Name: \_\_\_\_\_  
Street: \_\_\_\_\_  
Facility/Complex: \_\_\_\_\_ Room # \_\_\_\_\_  
Town/State/Zip: \_\_\_\_\_  
HomePhone: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Sex: M F

Soc Sec Number: \_\_\_\_ -- \_\_\_\_ -- \_\_\_\_

Marital Status: Married Widow(er) Divorced Single

Ethnic Background \_\_\_\_\_

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: \_\_\_\_\_

Who is calling in referral?  
Name: \_\_\_\_\_