Demographic Intake Form

Date of Intake: ____________________
Referred by: ____________________
1st Visit Date: ____________________

Practice: ____________________ Address: ____________________ Phone: __________ Email: ____________________

PATIENT INFORMATION

Name: ____________________
Address: ____________________
Facility/Complex: ____________________ Room # ________
City: ____________________
State: ____________________ Zip Code: ____________
Primary Phone: ____________________
Secondary Phone: ____________________
Birth Date: ____________________ O Male O Female
Social Security Number: ______ – ______ – ______ *(helpful for billing)*

Marital Status:
O Married O Divorced O Widow (er) O Single

Race:
O White
O Black or African American
O Asian
O American Indian or Alaska Native
O Native Hawaiian or Other Pacific Islander

Ethnicity:
O Hispanic
O Non-Hispanic

Lives alone: O Yes O No
If no, who does patient live with: ____________________

EMERGENCY CONTACT INFORMATION

Contact #1 Name: ____________________
Relationship to Patient: ____________________
Primary Phone: ____________________
Secondary Phone: ____________________
Contact you regarding visits/times/etc? O Yes O No
Contact you with medical results/advice? O Yes O No

Contact #2 Name: ____________________
Relationship to Patient: ____________________
Primary Phone: ____________________
Secondary Phone: ____________________
Contact you regarding visits/times/etc? O Yes O No
Contact you with medical results/advice? O Yes O No

RESPONSIBLE FINANCIAL PARTY INFORMATION

Name: ____________________
Address: ____________________
City: ____________________
State: ____________________ Zip Code: ____________
Primary Phone: ____________________
Secondary Phone: ____________________
Relationship to Patient: ____________________

PRIMARY INSURANCE INFORMATION

(attach a copy of the front and back of insurance card)

Insurance Company: ____________________
Subscriber Name: ____________________
Subscriber Date of Birth: ____________________
Group Number: ____________________
Policy / ID Number: ____________________
Claims Address: ____________________
City: ____________________
State: ____________________ Zip Code: ____________

SECONDARY INSURANCE INFORMATION

(attach a copy of the front and back of insurance card)

Insurance Company: ____________________
Subscriber Name: ____________________
Subscriber Date of Birth: ____________________
Group Number: ____________________
Policy / ID Number: ____________________
Claims Address: ____________________
City: ____________________
State: ____________________ Zip Code: ____________

CURRENT/PREVIOUS PRIMARY CARE PROVIDER

Name: ____________________
Phone: ____________________
Fax: ____________________

OTHER INFORMATION

How did you hear about us? ____________________
____

Do you have home health? O Yes O No
Agency name: ____________________
Agency phone: ____________________
Durable medical equipment in the home? O Yes O No
(List any medical equipment utilized such as bedside commode, walker, wheelchair, hospital bed, tube feeding pump, etc.)

Equipment	Supplier Name and Phone