NEW PATIENT INTAKE FORM
Fax 615.712.7026

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: ____________

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*

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: ____________

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

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*

OTHER INSURANCE CARRIER *(IF APPLICABLE)*: ____________
POLICY NUMBER: ____________ GROUP NUMBER: ____________
TYPE OF POLICY: ❑ *HMO* ❑ *PPO* ❑ *TRADITIONAL* ❑ *PFFS* PHONE: ____________

IN-OFFICE USE ONLY

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

DATE OF INTAKE: ____________ EMPLOYEE COMPLETING INTAKE: ____________
ASSIGNED VPA PHYSICIAN: ____________ FIRST VISIT DATE: ____________
CENTRICITY ACCOUNT NUMBER: ____________ MAPSCO CODE *(IF APPLICABLE)*: ____________