Patient Intake Form

HOMEMD HOUSECALL SERVICES

Patient Information: Please use full legal name.

☐ *Memory Care* ☐ *Assisted Living* ☐ *Group Home* ☐ *Independent Living*

First Name: _____ Last Name: _____ M.I.: ____

Date of Birth: ____/____/____ Social Security #: _____ Gender: ☐ M ☐ F ☐ Other

Facility Name: _____ Phone Number: _____ City/State: _____

Patient Room #: _____ Patient personal cell or direct phone only *(if applicable):* _____

Marital Status *(choose one)*: ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Single

Race/Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
Choose one or more ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Declined ☐ Unknown

Primary Language: _____ Country of Origin: _____ ☐ Interpreter Services Needed

Drug Allergies ***(required)***: _____

Insurance: Please submit a copy of insurance cards.

Medicare ID #:_____ (If on Medicare, ID ***required*** for enrollment.)

Primary Plan: _____ Policy ID #: _____ Group #: _____

Secondary Plan: _____ Policy ID #: _____ Group #: _____

Prescription Drug Coverage Name: _____ Plan ID #: _____

Legal Representative

I acknowledge and agree that by signing this form as a Legal Representative for the patient, I swear and attest that I am legally authorized to act and make decisions on behalf of the patient. I am required to provide a copy of valid and effective documentation outlining my role as Legal Representative in order to receive related communications. Upon signing the form or any other required documentation from HomeMD Housecall Services as a Legal Representative for the patient, I hereby release and hold harmless HomeMD Housecall Services and its representatives from any claims or damages arising from HomeMD Housecall Services reliance on my attestation that I am Legal Representative.

Name: _____ Relationship to Patient: _____

Mobile Phone #: _____ Secondary Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Billing Contact:

☐ Same as Healthcare Decision Maker ☐ Self ☐ Other _____

Name: _____ Relationship to Patient: _____

Mobile Phone #: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Services Requested for In-home Care

- ☐ **Primary Care:** Nurse practitioners can navigate all medical needs whilecoordinating care with specially trained medical staff including your current medical team
- ☐ **Palliative Care:** Coordinated care with PCP, for patients with increasing needs andfrequent symptom management
- ☐ **Remote Monitoring Care:** Cloud-connected blood pressure cuffs, weight scales,and Dexcom Devices
- ☐ **Podiatry Care:** Foot, ankle, and nail services
- ☐ **Behavioral Health Care:** Coordinated care with psych practitioners, RN's, SocialWorkers that can order/monitor/treat depression, isolation, anxiety, dementia, and abnormal psychology, complemented by our counseling services
- ☐ **Wound Care:** Specialty certified wound and ostomy team