**Patient Intake Sheet**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Demographics**

**Patient’s Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­­­­­­­First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name: \_\_\_\_\_**

**Suffix: \_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Male/Female: \_\_\_\_**

**Patient Physical Address (*if different from physical address)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_**

**Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you consent to receiving electronic correspondence via email/text about appointments, billing, etc:**

**Yes\_\_\_\_\_\_ No\_\_\_\_\_\_**

**Caretaker Information:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you consent to receiving electronic correspondence via email/text regarding patient: Yes No**

**Emergency Contact**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance**

**Primary Insurance: MEDICARE ADVANTAGE HMO/PPO**

**Policy #: Group ID:**

***Eligibility and Verification:***

***Date: Reference number:***

***Agent Name: Patient Eligibility: Effective Date:***

***Copay:***  ***Coinsurance:***  ***Deductible:***

***Has deductible been satisfied: Yes No***  ***Amount remaining:***

**Secondary Insurance:**

**Policy #:**

**Prior Auth:**

**Number of Visits Approved:**

**Consent to Treat**

**Does Advanced Practice House Calls have patient consent to assess and treat? (Check the box if yes).**

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**Chronic Care Management Consent:**

We encourage you to participate in the Chronic Care Management (CCM) program. Chronic Care Management (CCM) services help manage your health between office visits. The program provides a series of non-face-to-face activities and additional services especially for our CCM patients. You will have a dedicated Care Team that is familiar with your conditions - We actively help you manage all your medications - We help coordinate your care with your other doctors - We share your health information only with other authorized providers. Each month, after we provide you with a minimum of 20 minutes of non-face-to-face services, we will bill your insurer(s). Either you or your supplementary insurer may be responsible for any deductible or co-pay.

**Does Advanced Practice House Calls have patient consent from the patient to provide Chronic Care Management Service? (Check the box if yes).**

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**For Transitional Care Management:**

**Patient discharge date from hospital/rehab:**

**Patient contacted 2 days after discharge: 1st attempt \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2nd attempt \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is patient establishing with us as PCP (Y/N)? \_\_\_\_\_\_\_\_**

**If the patient will only be seen for transitional visits, who is the patient’s PCP?**

**PCP Phone: Fax:**

**Health History**

**Primary Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other Health Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NKDA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dialysis (Y/N)? \_\_\_\_\_\_\_\_\_\_ Dialysis days: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Bound Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you use an Assistive Device? (Wheelchair, walker, cane): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you require Assistance by another person to leave your home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Complex and Multiple medical, psychiatric and Social Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Disabled\_\_\_\_\_\_\_\_\_\_\_\_**

 **Too sick and cannot make it to Doctors Clinic\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Need intermittent skilled nursing care; or physical, speech, or occupational therapy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other Pertinent Information**

**Referral Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Referral Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Health Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Patient Scheduled: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Person Completing Intake Form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**