DOCTORS MAKING HOUSECALLS

Patient Information: Every Field Needs to be Filled

Last Name _____ First Name _____ MI _____

Sex: M / F DOB _____/_____/_____ Soc. Sec. # _____-_____-_____

Community name if not at home _____ **Apt or Room #** _____

Address _____ City _____ State _____ Zip _____

Phone: Home (_____) _____-_____ Cell (_____) _____-_____ E-mail _____

Emergency Contact Person (Responsible party? Yes / No)

Last Name _____ First Name _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Phone: Home (____) _____-_____ Cell (____) _____-_____ Work (____) _____-_____ Ext _____

E-mail Address _____ **POA? Y / N (attach copy)**

Secondary Emergency Contact Person (Not Residing with Patient)

Last Name _____ First Name _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Phone: Home (____) _____-_____ Cell (____) _____-_____ Work (____) _____-_____ Ext _____

E-mail Address _____ **POA? Y / N (attach copy)**

Form of Payment Needed for Deductibles, Co-Insurance, and Trip Charges: Please Check One

☐ **Credit Card**

Credit Card Type _____ #_____ Exp_____/_____

Card Holder's Name _____ CVC2 (3 digit code, Amex is 4 digits)_____

Cardholder's Address _____

☐ **Bank Checking Account**

Bank Name _____ Name on Account _____

Routing #_____ Checking Account # _____

☐ **Deposit of $250.-$500.00 is Included**

Primary Insurance Policy - Name of Insurance_____

Policy, Subscriber, etc.# _____ Grp #_____

Claims Address (not needed for Medicare)_____

City _____ State _____ Zip _____

Secondary Insurance Policy/Medicare Supplement - Name of Insurance _____

Policy, Subscriber, etc.# _____ Grp #_____

Claims Address (not needed for Medicare) _____

City _____ State _____ Zip _____

Preferred Pharmacy _____ **Preferred Hospital** _____

Prior PCP, Specialists, Hospital Visits _____

Allergies_____

Medications (attach or list with dose and frequency) _____

Medical Records- Please Attach.