PATIENT INTAKE FORM

family medical equipment & supply

The Plaid Daisy

FIRST NAME	MIDDLE NAME		LAST NAME	
ADDRESS	CITY		STATE / ZIP	
HOME PHONE	CELL PHONE		WORK PHONE	
SSN	DATE OF BIRTH	SEX	HEIGHT	WEIGHT
EMAIL ADDRESS				

GUARANTOR / POA / RESPONSIBLE PARTY		
ADDRESS	CITY	STATE / ZIP
HOME PHONE	CELL PHONE	WORK PHONE
SSN	DATE OF BIRTH	
PLACE OF EMPLOYMENT	RELATIONSHIP TO PATIENT	

Would you like your bills / invoices emailed to you? ☐ Yes ☐ No

Location of patient if not present:

If primary language is NOT English — please state here:

EMERGENCY CONTACT NOT LIVING WITH PATIENT — REQUIRED. MUST BE COMPLETED.

NAME	RELATION	PHONE
ADDRESS	CITY	STATE / ZIP

How long have you had this condition?	Have you ever used Medical Equipment before?

How did you hear about Family Medical / The Plaid Daisy?

Allow Release of Information to:

DOCTOR NAME	DOCTOR PHONE
DIAGNOSIS / CONDITION	
IMPORTANT MEDICAL INFORMATION — SURGERY / ALLERGIES	

PRIMARY INSURANCE		
INSURED NAME	DATE OF BIRTH	SSN
SECONDARY INSURANCE		
INSURED NAME	DATE OF BIRTH	SSN
TERTIARY INSURANCE		
INSURED NAME	DATE OF BIRTH	SSN

FOR STAFF USE ONLY: