Northview Medical House Calls PLC
1184 Cleaver Rd Suite 300
Phone: 888-758-5709 Fax: 888-491-7220

Demographic Intake Form

*****PATIENT INFORMATION*****

Name:_____

Street:_____

Facility/Complex: _____

Town_____

State_____

Zip:_____

Home Phone:_____

Date of Birth: _____

Social Security #_____

Marital Status ☐Single ☐Married ☐Widow

Lives alone ☐Yes ☐No

Lives with:_____

*****EMERGENCY CONTACT INFORMATION*****

Name:_____

Relationship to Patient:_____

Phone:_____

Contact you with Visits/times/etc: **Yes or No**

Name:_____

Relationship to Patient:_____

Phone:_____

Contact you with Visits/times/etc: **Yes or No**

*****RESPONSIBLE PARTY INFORMATION (Billing Address)*****

Name_____

Street_____

Town_____

State_____

Zip_____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Relationship to Patient:_____

*****PRIMARY INSURANCE*****

Insurance company_____

Claim address:_____

City:_____

State:_____

Zip:_____

Group Number_____

Policy ID Number_____

Name on Card:_____

Date of Birth:_____

Soc Sec Number:_____

*****SECONDARY INSURANCE*****

Insurance company_____

Claim address:_____

City:_____

State:_____

Zip:_____

Group Number_____

Policy ID Number_____

Name on Card:_____

Date of Birth:_____

Soc Sec Number:_____

*****PRIMARY PHYSICIAN*****

Name:_____

Phone:_____

Fax:_____

*****OTHER INFO*****

How did you hear about us?_____

Do you have home health?_____

Name: _____

Phone:_____

Who is calling in referral?_____