PROFESSIONAL HOME HEALTH CARE, INC

PHONE:(817) 268- 0010
FAX:(817) 268- 0722

INTAKE

PATIENT INFORMATION

NAME: _____
ADDRESS: _____ APT# _____
CITY: _____ STATE: ___ ZIP: _____
PHONE: _____ DOB: _____
SS#: _____ **MEDICAID#** _____
MEDICARE# _____

EMERGENCY CONTACT

NAME: _____
ADDRESS: _____ APT# _____
CITY _____ STATE ___ ZIP _____
PHONE(H) _____ (W) _____
RELATIONSHIP: _____

DIAGNOSIS

DIAGNOSIS ICD

_____
_____
_____
_____
_____
_____
_____

PRIMARY PHYSICIAN

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: ____
PHONE: _____ UPIN# _____
DATE LAST SEEN: _____
CONSULTING PHYSICIAN
NAME; _____
PHPONE: _____

REFERRAL INFORMATION

REFERRAL SOURCE: _____
PHONE#: _____
REFERRING FACILITY: _____
DISCHARGE DATE: _____

SURGICAL PROCEDURES

PROCEDURE ICD

_____
_____
_____
_____

INSURANCE INFORMATION

INSURANCE: _____
EMPLOYER: _____
POLICY#: _____
GROUP#: _____
PHONE#: _____

SKILLED CARE REQUESTED/ORDERS:

DNR: YES NO

SN _____ **PT** _____ **OT** _____ **ST** _____ **MSW** _____ **AIDE** _____

_____
_____
_____
_____
_____