PATIENT INTAKE FORM

Date:	Consultant Name:
Referral Name:	Phone #:

PATIENT DEMOGRAPHICS

Last Name:	First Name:		M.I.	Phone:	
Street Address:		City:		State:	Zip:
DOB:	Sex: M F	Ht:	Wt:	Social Security #:	
Patient Cell Phone:		Patient Email:			
Emergency Contact / Responsible Party:				Phone:	

INSURANCE INFORMATION

Primary Insurance: ❑ Medicare ❑ Medicaid ❑ Other		Secondary Insurance: ❑ Medicare ❑ Medicaid ❑ Other	
Name:		Name:	
Address:		Address:	
Phone:		Phone:	
Policy #:	Group ID #:	Policy #:	Group ID #:

PHYSICIANS DEMOGRAPHICS

Physician Name:		NPI #:	
Street Address:	City:	State:	Zip:
Contact:	Phone:	Fax:	

ICD10 CODES:	1.	2.	3.	4.

HEALTH & MOBILITY

❑ CVA / Stroke R / L side	❑ Diabetes Type I or II	❑ COPD or Asthma	❑ Rheumatoid Arthritis
❑ Back or Spine Problems	❑ Foot Problems	❑ Oxygen Use	❑ Osteoarthritis
❑ Knee Problems	❑ Poor Circulation	❑ Dementia	❑ Other
❑ Hip Problems	❑ DJD	❑ Bed Sores	
❑ Fall Risk	❑ Heart Disease	❑ Trouble Sleeping	

PRODUCT INFORMATION

HCPS CODE	PRODUCT DESCRIPTION	COLOR	SIZE	L/R	QTY

DW Medical supply * 1524 Centinela Ave Inglewood CA 90302 *PH:(310) 330-0162 *Fax:(310) 330-0199

Authorization/Consent for Care/Service: I have been informed of the home care options available to me and of the selection of providers from which I may choose. I authorize DW Medical Supply under the direction of the prescribing physician, to provide home medical equipment, supplies and services as prescribed by my physician. I hereby assign all benefits and payments to be made directly to DW Medical Supply for any home medical equipment, supplies and services furnished to me. I hereby request and authorize DW Medical Supply, the prescribing physician, hospital, and any other holder of medical information relevant to service, to release information upon request, to DW Medical Supply, any payer source, physician, or any other medical personnel or agency involved with service.

SIGNATURE: _____ DATE: _____