CORE CARE TECHNOLOGIES, INC.
Customer Intake Form

New Acct.☐ Old Acct ☐

Order Date _____ **Time** _____**AM/PM CSR** _____ **Delivery Date** _____ **Time** _____

PATIENT INFORMATION **Is this their Primary Address (6mos or >)? ☐ Y ☐ N If No, obtain the primary address and the delivery address**

Patient Name: _____ DOB _____SS# _____

Address: _____ Apt# _____

City: _____ State: _____Zip: _____Home Tel #:_____ Work Tel: _____

Cell Tel#_____ Height:_____ Weight:_____ Gender: _____ Male _____ Female

Emergency Contact: _____Tel _____ Relationship: _____

Address: _____ City & State _____Phone # _____

PHYSICIAN INFORMATION

Doctors Name _____ NPI # _____

Address_____

City _____ State _____ ZipCode _____ Tel # _____Fax# _____

Date last seen by MD: _____

Hospital/nursing home _____Admission Date: _____ Discharge Date: _____

INSURANCE COVERAGE: ☐ MEDICARE ☐MEDICAID ☐ PRIVATE INSURANCE ☐PRIVATE PAY

Primary Insurance _____ Phone # _____

Subscriber/Policy Holder Name _____Relationship _____DOB _____

Policy # _____ Group # _____ Tel #_____

Secondary Insurance _____ Phone # _____

Subscriber/Policy Holder Name _____Relationship _____DOB _____

Policy # _____ Group # _____ Tel #_____

Patient aware of co-pay and deductible? ☐Y ☐N Explained at time of intake or set-up ☐ Y ☐ N

PRESCRIPTION INFORMATION :

Diagnosis 1: _____Diagnosis 2: _____ Diagnosis 3:_____

Equipment/Supplies :_____

Has Equipment ever been purchased or rented in the past? ___Yes____No Date of rental/purchase:_____

IF YES, NAME OF SUPPLIER_____PHONE#_____

WORKER'S COMPENSATION INFORMATION:

Employer:_____ **Phone#**_____ **Date of Injury:**_____

Insurance Carrier:_____ **Phone#**_____ **Ext:** _____

Claim#_____ **Adjuster Name:** _____

AUTO ACCIDENT INFORMATION:

Insurance Carrier:_____ **Phone#**_____ **Ext:** _____

Claim#_____ **Adjuster Name:** _____

Date of Accident:_____

ARE YOU CURRENTLY RECEIVING HOME CARE SERVICES: _____YES _____ NO

If Yes, Name of Home Care Agency_____ Phone# _____

Nurse:_____ Date Services Began:_____

FOR OFFICE USE ONLY:

___ Customer info complete including height, weight and second phone number

___ Physician info and NPI

___ Emergency Contact complete

___ Patient Diagnosis info correct & relevant to equipment/supplies provided

___SNF/Hospital D/C date complete and equipment/supplies delivered on/after D/C date

___ Insurance verification form completed w/reference number, date and signature

This chart has been reviewed, information verified and ready to be sent to billing.

Employee Name:_____ **Date:**_____