United Medical House Calls

Suffolk: (631) 626-1006
Nassau: (631) 736-1510
Fax: (631) 477-6219
www.medicalhousecalls.com
Email: info@medicalhousecalls.com

New Patient Intake Form

Patient Information:

First Name: _____ **Last Name:** _____

DOB: _____ **SSN:** _____ **Sex: M / F**

Reason for Appointment: _____

Discharge Patient: Y / N **Hospital or Nursing Home:** _____

Referral Information:

Name: _____ **Facility:** _____

Contact #: _____

Interested in receiving follow-up call for Referred Patient: Y / N

Patient's Contact Information:

Home Phone: _____ **Mobile Phone:** _____

Email: _____

Preferred Method of Communication: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Type of Residence: Private Home / Apartment Complex / Other

Aide in Home: Y / N

Receiving Skilled Nursing Care: Y / N

Health Care Proxy Information:

Name: _____ **Relationship to Patient:** _____

Contact #: _____

Patient's Insurance Information:

Primary Insurance: _____ **Member ID:** _____

Contact # for Providers: _____

Secondary Insurance: _____ **Member ID:** _____

Contact # for Providers: _____

Previous Primary Care Provider:

Name: _____ **Fax #:** _____

Prescriptions:

Preferred Pharmacy: _____

Location: _____ **Zip Code:** _____