Client/Patient Intake Form

DATE: _____ DOB: _____/_____/_____ M _____ F _____

FULL NAME: _____ PHONE _____

ADDRESS: _____ CELL#: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____

HT: _____ WT: _____ SS#: _____

MEDICARE#: _____ MEDICAID#: _____

MEDICARE HMO: _____ POLICY#: _____

PRIVATE INSURANCE_____

INCLUDE A COPY OF YOUR DRIVERS LICENSE UPON RECEIPT
INCLUDE A COPY OF ALL INSURANCE CARDS UPON RECEIPT

COMPANY NAME: _____

POLICY#: _____ GROUP#: _____

PHYSICIAN INFORMATION:

Surgery Date _____

PCP: _____ NURSE: _____

ADDRESS: _____ NPI #: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE#: _____ FAX#: _____

CONTACT INFORMATION:

DOES PATIENT LIVE ALONE? YES___ NO___

NEAREST RELATIVE:

NAME: _____

ADDRESS: _____

PHONE#: _____

RELATION: _____

CAREGIVER NEEDED? YES____NO____

MASTECTOMY___ LEFT___RIGHT___ BILATERAL___

LUMPECTOMY___ LEFT___RIGHT___ BILATERAL___

POLAND SYNDROME_____

FAILED RECONSTRUCTION. YES___ NO___

CHEMO. YES____ NO___ RADIATION YES___NO___

SENSITIVITY YES___NO___

LYMPHEDEMA. YES___NO___

Chemo Yes_____No_____ Radiation Yes___ No____ Sensitivity. Yes____ No_____

REFERRAL FROM: _____

DO WE HAVE DR'S ORDER? _____ PT WANTS: _____

RELATED DIAGNOSIS FOR SERVICE(S) PROVIDED: _____