One On One
MEDICAL CARE

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INTAKE FORM

PATIENT'S INFORMATION

Name: _____ Date Of Birth: _____

Phone #:_____ FAX #: _____

Address: _____

I, _____ hereby give permission to authorize the Provider(s) of **One On One Medical Care Inc.**, to perform all necessary assessment and treatments. I understand that I may refuse or terminate the services at any time. I give permission to **One On One Medical Care Inc.** to use and disclose protective health information about me to carry out treatment, payment, healthcare operations, receive and release information patient to my care.

_____

Patient's Signature or Legal Representative Signature (if patient can not sign)

Referral form: _____ Date: _____

Telephone #: _____ Source: _____

Note: Only for Patients from Hospital/Rehab Facility:

Attachments: _____Face sheet _____H & P _____Labs/Diagnostics _____Medication List

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Insurance ID #: _____ Insurance ID #: _____

REASON FOR REFERRAL

Discharged from Hospital/Rehab Facility: _____ D/C Date: _____

Patient is using: Cane: _____ WheelChair: _____ Walker: _____ Other(s): _____

Other reasons: _____

Additional Comments: _____

_____

For One On One Medical Care Inc. Office use only:

Eligibility: _____Yes _____No Note: _____

Date Scheduled for Visit: _____ Provider Name: _____