Please print clearly

INTAKE FORM

Ordered by: _____ Facility Representing: _____

BENEFICIARY GENERAL INFORMATION

Patient Name:	SS #:	Gender: M ☐ F ☐
Delivery Address:		Phone:
City,State,Zip:		County:
Date of Birth:	Marital Status: Married ☐ Single ☐	Other ☐
Height: Weight:	Diagnosis for Supplies:	
Nursing Facility ☐ Assisted Living ☐	Residential Apartment Living ☐	Own Home ☐

BENEFICIARY FINANCIAL/RESPONSIBLE PARTY INFORMATION

Name of Financially Responsible Party:	Relationship:
Billing Address:	
City, State, Zip:	County:
Phone:	Alternate Phone:

BENEFICIARY INSURANCE INFORMATION

Primary Insurance:		Policy #
Address:		City, State, Zip:
Name of Insured (If Not Beneficiary):		Relationship: DOB:
Is Patient Under Episode:	Hospice ☐ Home Health ☐	Medicare Part A ☐
Agency Name:		Phone:
Dates of Coverage:	to	
Secondary Insurance:		Policy #:
Address:		City, State, Zip:
Medicaid: Kansas ☐	Oklahoma ☐ Missouri ☐	Medicaid #:

ORDERING PHYSICIAN INFORMATION

Name:	
Address:	City, State, Zip:
Phone:	Fax:

PRIMARY CARE PHYSICIAN INFORMATION

Same as Ordering Physician ☐ Name:	
Address:	City, State, Zip:
Phone:	Fax: