HCCI
HOME CENTERED CARE INSTITUTE

Demographic Intake Form

Date of Intake: _____
Referred by: _____
1st Visit Date: _____

PATIENT INFORMATION

Name: _____
Address: _____
Facility/Complex: _____ Room # _____
City: _____
State: _____ Zip Code: _____
Primary Phone: _____
Secondary Phone: _____
Birth Date: _____ O Male O Female
Social Security Number: _____ – _____ – _____ *(helpful for billing)*

Marital Status:
O Married O Divorced O Widow (er) O Single

Race:
O White
O Black or African American
O Asian
O American Indian or Alaska Native
O Native Hawaiian or Other Pacific Islander

Ethnicity:
O Hispanic
O Non-Hispanic

Lives alone: O Yes O No
If no, who does patient live with: _____

EMERGENCY CONTACT INFORMATION

Contact #1 Name: _____
Relationship to Patient: _____
Primary Phone: _____
Secondary Phone: _____
Contact you regarding visits/times/etc? O Yes O No
Contact you with medical results/advice? O Yes O No

Contact #2 Name: _____
Relationship to Patient: _____
Primary Phone: _____
Secondary Phone: _____
Contact you regarding visits/times/etc? O Yes O No
Contact you with medical results/advice? O Yes O No

RESPONSIBLE FINANCIAL PARTY INFORMATION

Name: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Primary Phone: _____
Secondary Phone: _____
Relationship to Patient: _____

PRIMARY INSURANCE INFORMATION

(attach a copy of the front and back of insurance card)
Insurance Company: _____
Subscriber Name: _____
Subscriber Date of Birth: _____
Group Number: _____
Policy / ID Number: _____
Claims Address: _____
City: _____
State: _____ Zip Code: _____

SECONDARY INSURANCE INFORMATION

(attach a copy of the front and back of insurance card)
Insurance Company: _____
Subscriber Name: _____
Subscriber Date of Birth: _____
Group Number: _____
Policy / ID Number: _____
Claims Address: _____
City: _____
State: _____ Zip Code: _____

CURRENT/PREVIOUS PRIMARY CARE PHYSICIAN

Name: _____
Phone: _____
Fax: _____

OTHER INFORMATION

How did you hear about us? _____
_____
Do you have home health? O Yes O No
Agency name: _____
Agency phone: _____
Durable medical equipment in the home? O Yes O No
(List any medical equipment utilized such as bedside commode, walker, wheelchair, hospital bed, tube feeding pump, etc.)

Equipment	Supplier Name and Phone