All Pro Medical Supplies, Inc. **Website Intake Form**

PATIENT INFORMATION **Is this their Primary Address (6mos or >)? ☐ Y ☐ N If No, obtain the primary address and the delivery address**

Patient Name: ____ DOB ____________________ SS# ______________________________________

Address: ____ Apt# ____________

City: _____________________________ State: _________Zip: ______________ Home Tel #:__________________ Work Tel: ______________________

Secondary Contact: ______________________________________ Tel __________________________ Relationship: __________________________

Address: ____ City & State ________________________________ Phone # _______________________

PHYSICIAN INFORMATION

Doctors Name ____ UPIN # ________________________ Office Contact ____________________________

Address ____

City _________________________________ State ________ ZipCode ____________ Tel # (_____)_________________Fax# (____)__________________

Date last seen by MD: ______________ Dr. ____

Hospital/nursing home ____ Admission Date: ______________ Discharge Date: ____________________

Home Health Agency: ____ Nurse: ______________________ Telephone: ________________________

INSURANCE COVERAGE: ☐ **MEDICARE** ☐**MEDICAID** ☐ **PRIVATE INSURANCE** ☐**PRIVATE PAY** ☐ **Credit Card**

Primary Insurance ____ Phone # _______________________________

Insured Name ________________________________ Relationship ________________ DOB ____________Employer _______________________________

Policy # ________________________ Group # ___________________ Case Manager ____________________________ Tel #________________________

Secondary Insurance ____ Phone # _______________________________

Insured Name ________________________________ Relationship ________________ DOB ____________ Employer ______________________________

Policy # ________________________ Group # ___________________ Case Manager ____________________________ Tel #________________________

Patient aware of co-pay and deductible? ☐Y ☐N Explained at time of intake or set-up ☐ Y ☐ N

PRESCRIPTION INFORMATION **Patient's Height: _______in. Weight: _______lb**

Diagnosis 1: __________________________Diagnosis 2: _____________________________ Diagnosis 3: ______________________________________

Standard Precautions: ☐ Y ☐ N Infection: ________________________________ per referral ☐ AB ☐ BB

Rx ____Verbal Order ___ RX in hand ___ FAX ___

OXYGEN ________LPM ______Duration via ☐Cannula ☐ %Mask ____% ☐ Trach Mask _______% ☐ Bleed-In ______LPM

Qualification Data: _____%SaO_2 ______mmHg PaO_2 ☐ Room Air ☐ O_2 ______LPM ☐ At Rest ☐ During Exercise (Post Sat w/ O_2 required) ☐ At night

* **Must fax a copy of the lab report** Test Date ______________ Facility________________________Address ______________________________________

EQUIPMENT ORDERED

QTY	S/R	Equipment Requested	HCPC CODE		Delivery Date Request	HAS EQUIPMENT BEEN PREVIOUSLY RENTED / PURCHASED?
						☐ YES DATE ☐NO
						☐ YES DATE ☐NO
						☐ YES DATE ☐NO
						☐ YES DATE ☐NO
						☐ YES DATE ☐NO
						☐ YES DATE ☐NO
						☐ YES DATE ☐NO

****If Equipment has been previously rented or purchase, we require the name of supplier** ____

FAX this completed form to: 631-475-9014