K.C.'s MEDICAL HOME CARE SUPPLIES AND PHARMACY, INC.

ACHC ACCREDITED
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(770)-716-7678 * (770)-7161814 FAX
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***** ***INTAKE FORM***

Patient's Name:_____

Address:_____

City:_____ State:_____

Zip:_____Phone:_____

Gender:___ Male ___ Female

Date of Birth:_____

SSN:_____

Weight:_____ Height:_____

Related Diagnosis for Services Provided:

(1)_____(2)_____

(3)_____(4)_____

Ordering Physician's Office:_____

Physician Address:_____

_____

Phone:_____Fax:_____

Physician's License UPIN & NPI # ***(mandatory)***

_____

Nurse: _____

Patient's Insurance Coverage

Primary Insurance:_____

Policy Number:_____

Name of Insured:_____

Address:_____

Phone:_____

Date of Birth:_____

Secondary Insurance:_____

Policy Number:_____

Name of Insured:_____

Address:_____

Phone:_____

Date of Birth:_____

Services Ordered:

☐ Oxygen LPM_____ Method:_____

☐ Portable O2 Tank Required

☐ Nebulizer ☐ Rx *(please fax copy to number above)*

☐ CPAP Settings:_____

☐ CPAP Accessories: Mask, Tubing, Filters, Headgear

☐ Bi Level Settings:_____

☐ BiLevel Accessories: Mask,Tubing,Filters,Headgear

☐ Overnight Pulse Oximeter

☐ Blood Glucose Meter

Supplies: ☐ Strips ☐ Lancets ☐ Lancet Device

☐ Diabetic Shoes & Inserts

☐ Walker: Weight:_____Height:_____*(mandatory)*

☐ Walker w/wheels
Weight:_____Height:____*(mandatory)*

☐ Bedside Commode

☐Wheelchair Weight:_____Height:_____*(mandatory)*

☐ Electric Wheelchair OR ☐ Electric Scooter

☐ Patient Lift

☐ Hospital Bed

☐ Breast Prosthesis ☐ Bra

☐ Other Home Healthcare Supplies:_____

_____

_____

_

Special Instructions:_____

_____

_____

_____