myhomedoctor

My Home Doctor, LLC
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PATIENT FORMS

# Patient intake form

STEP 1

## Who is filling out this form?

A patient, a family member or a caregiver can complete this form.

- ◯ The patient
- ◯ Family member
- ◯ Caregiver
- ◯ Legal representative (POA or guardian)

YOUR NAME (IF NOT THE PATIENT)

RELATIONSHIP TO THE PATIENT

YOUR PHONE

YOUR EMAIL

STEP 2

## Patient information

FIRST NAME *

MIDDLE NAME

LAST NAME *

PREFERRED NAME

DATE OF BIRTH * mm/dd/yyyy

SEX

PREFERRED LANGUAGE

PATIENT PHONE *

PATIENT EMAIL

STEP 3

# Where we will visit

TYPE OF RESIDENCE

- ◯ Private home or apartment
- ◯ Assisted living facility (ALF)
- ◯ Group or adult family care home
- ◯ Other

FACILITY NAME AND ROOM NUMBER (IF ANY)

FACILITY PHONE

STREET ADDRESS *

APARTMENT, UNIT OR BUILDING

CITY *

STATE *

ZIP *

ANYTHING OUR CLINICIAN SHOULD KNOW BEFORE VISITING?

Gate or door code, parking, pets, best entrance, someone who must be present

**CONFIDENTIAL:** This form contains protected health information (PHI). Do not leave it unattended or share it with anyone other than My Home Doctor or your authorized representative.

STEP 4

# Health plan coverage

We need every health plan the patient is covered by. Please have the member card(s) ready.

## Primary health plan

HEALTH PLAN NAME *

e.g. the name on the member card

PLAN TYPE *

MEMBER ID *

GROUP NUMBER

POLICY HOLDER, IF NOT THE PATIENT

## Secondary health plan (if any)

HEALTH PLAN NAME

e.g. the name on the member card

PLAN TYPE

MEMBER ID

GROUP NUMBER

POLICY HOLDER, IF NOT THE PATIENT

## Other health plan (if any)

HEALTH PLAN NAME

e.g. the name on the member card

PLAN TYPE

MEMBER ID

GROUP NUMBER

POLICY HOLDER, IF NOT THE PATIENT

STEP 5

## Caregiver and emergency contact

PRIMARY CAREGIVER NAME

RELATIONSHIP

CAREGIVER PHONE

CAREGIVER EMAIL

EMERGENCY CONTACT NAME *

EMERGENCY CONTACT PHONE *

DOES THE PATIENT HAVE A HEALTH CARE SURROGATE, POWER OF ATTORNEY OR LEGAL GUARDIAN?

◯ Yes ◯ No ◯ Not sure

NAME OF SURROGATE, POA OR GUARDIAN

THEIR PHONE

STEP 6

## Current care team

CURRENT PRIMARY CARE DOCTOR

DOCTOR'S PHONE

SPECIALISTS THE PATIENT SEES

| SPECIALIST NAME | SPECIALTY | PHONE |
|---|---|---|
| | e.g. cardiology | |
| | e.g. cardiology | |
| | e.g. cardiology | |

PREFERRED PHARMACY

PHARMACY PHONE

HOME HEALTH AGENCY (IF ANY)

MEDICAL EQUIPMENT SUPPLIER (IF ANY)

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STEP 7

## Health history

### CURRENT CONDITIONS (CHECK ALL THAT APPLY)

- ☐ Heart failure
- ☐ COPD or lung disease
- ☐ Diabetes
- ☐ Kidney disease
- ☐ High blood pressure
- ☐ Dementia or memory loss
- ☐ Stroke
- ☐ Cancer
- ☐ Depression or anxiety
- ☐ Wounds or pressure sores
- ☐ Falls in the last year
- ☐ Other

### ER VISITS IN THE LAST 12 MONTHS

### HOSPITAL STAYS IN THE LAST 12 MONTHS

### MOST RECENT HOSPITAL DISCHARGE DATE

mm/dd/yyyy

### ALLERGIES (MEDICATIONS, FOODS, LATEX)

### CURRENT MEDICATIONS

List them here, or have all medication bottles ready for the first visit

### MOBILITY

- ◯ Walks without help
- ◯ Uses a cane or walker
- ◯ Uses a wheelchair
- ◯ Mostly in bed

### HELP NEEDED WITH DAILY ACTIVITIES (CHECK ALL THAT APPLY)

- ☐ Bathing
- ☐ Dressing
- ☐ Eating
- ☐ Toileting
- ☐ Moving around the home
- ☐ Managing medications

### USES OXYGEN AT HOME?

- ◯ Yes
- ◯ No

STEP 8

## Advance directives

Please check any the patient has, and have copies available at the first visit.

- ☐ Living will
- ☐ Do Not Resuscitate Order (DNRO)
- ☐ Health care surrogate designation
- ☐ Durable power of attorney
- ☐ None
- ☐ Not sure

STEP 9

## How should we reach you?

**WHO SHOULD WE CALL TO SCHEDULE VISITS?**

**BEST TIME TO REACH**

**WE MAY**

- [ ] Send text messages
- [ ] Leave voicemails with visit details

STEP 10

## Acknowledgment and signature

- [ ] I acknowledge that I have received, or have been offered, a copy of My Home Doctor's Notice of Privacy Practices.
- [ ] The information on this form is accurate to the best of my knowledge.

**SIGNATURE OF PATIENT OR REPRESENTATIVE** *

SIGN HERE

**PRINTED NAME** *

**DATE** *

mm/dd/yyyy