Geritom Medical
CREATING WAYS TO BETTER YOUR LIFE

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Specialty Client Intake

1. Patient Information:

Patient Name_________________________ **Birthdate**__________________ **Sex** Male □ Female □
Social Security #____________________ **Phone #**____________________ **Email**______________________
Address_____________________________ **City**_______________ **State**_______ **Zip**_________________
Referred By______________________ **Case Manager**_____________________ **Phone #**________________
Emergency Contact______________________ **Relationship**___________________ **Phone #**_______________

2. Insurance & Billing Information: (Please Include Copies of Insurance Cards if Available)

MA#_______________________________ **Other Insurance**__________________________________
Cardholder ID #_____________________________ **Group #**______________________________
Insurance Phone #____________________ **Person Responsible for Payment**_________________________
Relationship______________________________ **Phone #**____________________

3. Medical Information:

Do you have any allergies? No □ Yes □ Please list them_____________________________________
Current Pharmacy__________________________ **Phone #**________________ **City**_____________________
Primary Doctor____________________________ **Phone #**_______________ **Clinic** _____________________
Specialty Doctor___________________________ **Phone #**________________ **Clinic**____________________

4. Diagnosis & Clinical Information:

HIV/AIDS □ Hepatitis C □ Psoriasis/Crohns/RA □ Oncology □ Cystic Fibrosis □ MS □ Other □__________________

If available, please provide any pertinent labs:
CD4 Count______________ **Date**______________
Viral Load_______________ **Date**_____________
Serum Creatinine________________ **Date**________________
Hgb Count__________________ **Date**________________
White Blood Cell Count________________ **Date**______________

5. Packaging & Medical Supplies:

Vials □ Reminder Cards □ Parata □ Dispill □ Not Sure □
Med Sheets: Yes □ No □
Medical Supplies____

6. Clinical Services: (Provided at No Charge)

Medication Therapy Management (MTM) with Pharmacist: Yes □ No □ Not Sure □
CareSpeak Mobile Text Adherence: Yes □ No □ Not Sure □

7. Patient Signature:

Patient Signature:______________________________________ **Date:**________________________