Geritom Medical
CREATING WAYS TO BETTER YOUR LIFE

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NEW CLIENT INTAKE

FACILITY NAME: ____

LAST NAME: __________________________FIRST NAME: ________________________________
DOB: ___________ SS# __________________________ MALE ___________ FEMALE ___________
ADDRESS: ____
CITY/STATE/ZIP CODE____
PHONE #______________________________ FAX #_____________________________________
EMAIL ADDRESS____

<u>INSURANCE & BILLING INFORMATION</u> *PLEASE INCLUDE COPY OF INSURANCE CARDS*
MA# ___________________________ OTHER INSURANCE CARRIER ________________________
CARDHOLDER I.D. # ___________________________ GROUP # ____________________________
INSURANCE PHONE # _______________________________
REP PAYEE: ____
RELATIONSHIP: _______________________ PHONE # __________________________________
ADDRESS TO SEND BILLS TO: ____
CITY_______________________________STATE____________________ZIP_____________

*****EMERGENCY CONTACT INFORMATION (THIS MUST BE FILLED OUT)**
NAME: ____________________________________ PHONE # _____________________________
RELATIONSHIP TO PATIENT: ____

<u>MEDICAL INFORMATION</u>
PRIMARY DOCTOR_________________________PHONE #________________________________
2nd DOCTOR________________________________PHONE #______________________________
DIAGNOSIS: ____
____
ALLERGIES: ____
____
CLOZAPINE/PHLEBOTOMIST NEEDS: YES______ NO______
MEDICATION THERAPY MANAGEMENT (MTM) WITH PHARMACIST: YES □ NO □ NOT SURE □

<u>PACKAGING</u>
PACKAGING:□VIALS □NURSING HOME CARDS □REMINDER CARDS □PARATA □NOT SURE
NOON SPLITS (DAY PROGRAM): YES_____ NO_____ DAYS (ex: M-F)__________TIME OF SPLIT_______
MEDSHEETS: YES_____ NO_____
WILL YOU NEED MEDICAL SUPPLIES OR OTC ITEMS? YES_____ NO_____

<u>MEDICAL SUPPLIES</u>
□ ENTERAL □ OSTOMY □ GLOVES
□ UROLOGICAL □ INCONTINENCE
□ CLEANING SUPPLIES □ OTHER_______________________________________

PLEASE INCLUDE COPIES OF ANY SIGNED PHYSICIAN ORDERS OR PRESCRIPTIONS FOR MEDICATIONS AND MEDICAL SUPPLIES
<u>IF WE NEED TO TRANSFER PRESCRIPTIONS FROM ANOTHER PHARMACY</u>
PREVIOUS PHARMACY NAME: _________________________ PHONE #:______________________
LOCATION (CITY OR STREET): __________________________