Geritom Medical
CREATING WAYS TO BETTER YOUR LIFE

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NEW CLIENT INTAKE

GROUP HOME OR FACILITY NAME (IF ANY): _____

LAST NAME: _____FIRST NAME: _____
DOB: _____ SS# _____ MALE _____ FEMALE _____
ADDRESS: _____
CITY/STATE/ZIP CODE_____
PHONE #_____ FAX #_____
EMAIL ADDRESS_____

INSURANCE & BILLING INFORMATION *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: _____
_____

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

MEDICAL INFORMATION
PRIMARY DOCTOR_____PHONE #_____
2ND DOCTOR_____PHONE #_____
DIAGNOSIS: _____
_____
ALLERGIES: _____
_____
CLOZAPINE/PHLEBOTOMIST NEEDS: YES_____ NO_____

PACKAGING
VIALS _____ REMINDER CARDS _____ NURSING HOME CARDS _____ 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_____

MEDICAL SUPPLIES

□ ENTERAL	□ OSTOMY	□ DIABETIC
□ UROLOGICAL	□ INCONTINENCE	□ GLOVES
□ CLEANING SUPPLIES	□ OTHER_____	

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