REHAB New Patient Packet **Britkare Home Medical Ltd.**

PATIENT PROFILE

NEW CURRENT

Personal

General Info

Last Name: _____
First Name: _____
Middle: _____
Suffix: _____
Birthdate: _____
SSN: _____

If Child

Mothers Name: _____
Address: _____
City, St. Zip: _____
Fathers Name: _____
Address: _____
City, St. Zip: _____

Billing Address

Address: _____
_____
City: _____
State: _____
County: _____
Country: _____
Postal Code: _____
Phone: _____
Fax: _____

Delivery Address **Same as Billing** ☐

Address: _____
_____
City: _____
State: _____
County: _____
Country: _____
Postal Code: _____
Phone: _____

Contacts

Emergency Contact

Last Name: _____
First Name: _____
Middle: _____
Address: _____
_____
City: _____
State: _____
County: _____
Country: _____
Postal Code: _____
Phone: _____
Fax: _____
Email: _____

Responsible Party

Last Name: _____
First Name: _____
Middle: _____
Address: _____
_____
City: _____
State: _____
County: _____
Country: _____
Postal Code: _____
Phone: _____
Fax: _____
Email: _____

Clinical

General

Gender: _____
Height (in) _____
Weight (lbs) _____
☐ Infectious Condition
Function Ability: _____
Practitioner: _____

Ordering Doctor

Name: _____

Primary Doctor **Same as Ordering** ☐

Name: _____

Referral

Name: _____

Marketing Rep

Gender: _____
Height (in) _____

Rendering Provider

Type: _____

Diagnosis Codes

D-Code 1 _____
D-Code 2 _____
D-Code 3 _____
D-Code 4 _____

Insurance

Workers Compensation

☐ Injury Related to Employment (Current or Previous)

☐ Injury Related to Auto Accident

State of Auto Accident _____

☐ Injury Related to Other Accident

Date of Onset _____

Status

Marital Status _____

Employement _____

Policy

Payor

Payor Level: _____

Insurance: _____

Insurance ID:

Payor Contact: _____

Policy Information

Start Date: _____

End Date: _____

Pay Pct. _____

Deductible: _____

Policy No: _____

Group No: _____

User 1 _____

User 2 _____

User 3 _____

User 4 _____

Relationship: _____

Payor ID: _____

Secondary Type: _____

Claim Code: _____

Type Code: _____

Insured

Last Name: _____

First: _____

Middle: _____

Birthdate: _____

Sex: _____

SSN: _____

Address: _____

_____

City: _____

State: _____

Country: _____

Postal Code: _____

Phone: _____

Employer: _____

Emp. Contact: _____

Delivery Driver: _____