



**PATIENT INTAKE FORM**

<b>DATE:</b>		<b>AMI CONTACT NAME:</b>	
<b>REFERRAL:</b>		<b>CONTACT:</b>	<b>PHONE:</b>
<b>PATIENT:</b>		<b>TREATING PHYSICIAN:</b>	
<b>PHONE:</b>		<b>PHONE:</b>	<b>FAX:</b>
<b>ADDRESS:</b>		<b>ADDRESS:</b>	<b>NPI:</b>
			<b>LIC#:</b>
<b>DOB:</b>	<b>HEIGHT:</b>	<b>Dx:</b>	<b>ICD-9:</b>
<b>SEX:</b>	<b>WEIGHT:</b>		<b>ICD-9:</b>
<b>SSN:</b>			<b>ICD-9:</b>
<b>PRIMARY INSURANCE:</b>		<b>SECONDARY INSURANCE:</b>	
<b>ID:</b>		<b>ID:</b>	
<b>EFFECTIVE DATE:</b>		<b>EFFECTIVE DATE:</b>	
<b>ELIGIBLE? [ ] YES [ ] NO</b>	<b>SNF? [ ] YES [ ] NO</b>	<b>ELIGIBLE? [ ] YES [ ] NO</b>	
<b>HMO? [ ] YES [ ] NO</b>	<b>PPO? [ ] YES [ ] NO</b>	<b>BASED ON PRIMARY ALLOWABLE AMOUNT? [ ] YES [ ] NO</b>	
<b>AMI PROVIDER: [ ] IN-NETWORK [ ] OUT-OF-NETWORK</b>		<b>AMI PROVIDER: [ ] IN-NETWORK [ ] OUT-OF-NETWORK</b>	
<b>COVERAGE PORTION: %</b>		<b>COVERAGE PORTION: %</b>	
<b>AMT OF DED: \$</b>	<b>AMT MET: \$</b>	<b>AMT OF DED: \$</b>	<b>AMT MET: \$</b>
<b>EMERGENCY CONTACT:</b>		<b>DME REQUESTED:</b>	
<b>RELATIONSHIP TO PATIENT:</b>			
<b>PHONE:</b>		<b>QUANTITY:</b>	<b>LENGTH OF NEED:</b>
<b>CURRENT CHAIR:</b>		<b>PT/OT:</b>	<b>PHONE:</b> <b>FAX:</b>
<b>DATE OF PURCHASE:</b>		<b>REPAIR QUOTE NEEDED? [ ] YES [ ] NO</b>	
<b>ADDITIONAL NOTES:</b>			