PHYSICIAN
HOUSECALLS

Patient Questionnaire

Patient Name:_____ DOB:_____

Gender: Male Female SSN:_____ Telephone:_____

Address:_____ Facility/Apt:_____

City/State:_____ ZIP Code: _____

Billing Address: _____

Email Address: _____

Emergency Contact:_____ Relationship to Pt:_____

Contact Telephone #1:_____ Contact Telephone #2:_____

Home Care/Hospice/Advantage CM Agency: _____

Current Pharmacy:_____

Billing and Insurance Information

Do you have a DPOA or Guardian? ☐ Y ☐ N

If yes, who? _____

DPOA or Guardian Address: _____

Are you responsible for your financials? ☐ Y ☐ N

If no, who? _____

Responsible Party Address: _____

Primary Insurance Information:

Insurance Company:_____ Number:_____

Name of Policy Holder:_____ Policy Holders DOB _____

Policy Holders SSN:_____ Group Number: _____

Insurance Phone #: _____

Submit claims to address: _____

Secondary Insurance Information:

Insurance Company:_____ Number:_____

Name of Policy Holder:_____ Policy Holders DOB _____

Policy Holders SSN:_____ Group Number: _____

Insurance Phone #: _____

Submit claims to address: _____