PHYSICIAN
HOUSECALLS

PATIENT EVALUATION QUESTIONNAIRE

Tele: _____ Fax: _____ VO Given by Whom: _____

REFERAL SOURCE: _____ Date: _____ DOB: _____

Patient Name: _____ SSN:_____

Address: _____ Facility/Apt: _____

Telephone: _____ City/Zip code: _____

Billing Address: _____ City/Zip code: _____

Important Directions: _____

Emergency Contact: _____ Relationship to Pt: _____

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

Current Pharmacy: _____ Home Care/Hospice/Advantage CM Agency:

Previous PCP:_____ _____

Is the patient's condition related to: Employment: **Y** **N** Auto Accident: **Y** **N** Other Accident: **Y** **N**

CODE STATUS

____Do Not Resuscitate and/or _____MOST form

Does the patient have a Living Will/ Advanced Directive? _____

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: _____