Desloge Home Oxygen & Medical Equipment

2510 Miccosukee Rd
Tallahassee, FL 32308
850-656-8900 • Fax 850-942-0220

Intake Order

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Height:	Weight:	Birth date: / /	Sex: ❑ M ❑ F	Cell phone no.: ( )

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Patient (or anyone in the household) being currently treated for an infectious condition?	❑ Yes ❑ No	If yes, what condition?

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is this patient covered by insurance? ❑ Yes ❑ No

Name of primary insurance:	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Desloge. I understand that I am financially responsible for any balance. I also authorize Desloge or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*