



DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Init: \_\_\_\_\_

Physical Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Alternate contact name and # \_\_\_\_\_ Relationship \_\_\_\_\_

Mailing Address (if different from above) or 2<sup>nd</sup> contact number for client:

\_\_\_\_\_

Patient's height: \_\_\_\_\_ Patient's weight: \_\_\_\_\_ Patient's preferred language: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Race: Caucasian African American Hispanic Asian/Pacific Native American Other

Are you a Veteran? Yes No

Insurance: None Medicare Medicaid Commercial Parkland Health Plus Other \_\_\_\_\_

Referring Physician/Hospital/Clinic/Social Worker/Agency:

\_\_\_\_\_

Their Contact #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Name \_\_\_\_\_

I certify that all information given in this application and supporting documents is correct to the best of my knowledge.

Client Signature: \_\_\_\_\_

**STAFF ONLY:**

Income Verified: Y / N (check stub, award letter copy provided and placed in chart)

Insurance Verified: Y/N (copy of coverage placed in chart and/ or medical social worker referral letter placed in chart)

Release of Information/ Liability Waiver signed: Y/N

Original DME Prescription: Y/N

Copy of ID: Y/N

Social Security number: Y/N

Staff member:

\_\_\_\_\_

Date: \_\_\_\_\_