

InHealth Technologies a division of Helix Medical LLC

CLIENT/PATIENT INFORMATION SHEET

(This form must be filled out and completed for continued service)

Referral Source (Person who referred you to InHealth): _____

Client/patient's Name: _____

Address: _____

Phone: (____)____-____ Social Security #: ____-____-____

Date of Birth: ____/____/____ Gender: Male ____ Female ____

E-mail Address: _____

Diagnosis for Service Provided: _____

Ordering/Prescribing Physician Name: _____

Address: _____ Phone: (____)____-____

City, State, Zip: _____

Emergency Contact:

Name: _____ Phone: (____)____-____

Next of Kin:

Name: _____ Phone: (____)____-____

Caregiver:

Name: _____ Phone: (____)____-____

Insurance Coverage (Medicare Primary ONLY):

Name of Insured: _____ Medicare ID#: _____

Address (If Different from Above): _____

Patient in Hospital/Care Facility or receiving Home Health assistance: Yes ___ No ___

If yes, Dates of Hospitalization/Care: _____