**PLEASE COMPLETE AND FAX THIS FORM *(OR FAX YOUR FORM: FACE SHEET / PATIENT DEMOGRAPHICS WITH THE FOLLOWING INFORMATION)***
**TO: DALLAS METROPLEX MEDICAL SERVICES FAX: 972.633.8779**

# INTAKE FORM

DATE OF INTAKE: _____ INTAKE TAKEN BY: _____

HOW DID YOU HEAR ABOUT US? _____

***PATIENT INFORMATION:***

NAME: _____ DOB: _____

ADDRESS: _____ APT #: _____

CITY: _____, STATE: TX, ZIP CODE: _____

PHONE #: _____ CELL # or OTHER CONTACT #: _____

RIGHT / LEFT HEIGHT: _____-_____ WEIGHT: _____ LBS.

(DX./ PROBLEMS WALKING/ CURRENT AIDS) :_____

_____

_____

***INSURANCE INFOMATION*:**

MEDICARE / SUPERIOR / MOLINA / OTHER: _____

MEMBER ID #: _____

***DOCTOR INFORMATION:***

NAME: _____

ADDRESS OF PRACTICE: _____

CITY: _____, STATE: TX, ZIP CODE: _____

PHONE #: _____ FAX #: _____ NPI #: _____

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**PROBLEM WITH CHAIR, SCOOTER OTHER EQUIPMENT NOTES:**

_____

_____

_____

_____

_____