COLE MEDICAL

PO Box 1481 | Rowlett, TX | 75030
ph: 945 • 426 • 8057 | fax: 833 • 471 • 4886
colemedical@icloud.com | www.colemedical.health

Clinical Intake / Patient Referral Form

How did you hear about us? _____ **Date:** _____ / _____ / _____

Contact Name: _____ **Cell Phone:** _____ - _____ - _____

PATIENT INFORMATION:

Patient name: _____ **DOB:** _____ / _____ / _____

Address: _____ **Apartment #:** _____ **Cell Phone:** _____ - _____ - _____

City, State _____ **Zip code:** _____

Social Security Number: _____ - _____ - _____ **Email:** _____

Gender: *(circle one)* M F Non-binary Trans - M Trans - F **Marital Status:** *(circle one)* Single Married

Race: _____ **Preferred Language:** *(circle one)* **English** **Spanish** **ASL** **Other:** _____

EMERGENCY CONTACT INFORMATION / MEDICAL POWER OF ATTORNEY *(if applicable)*:

Name: _____ **Cell phone:** _____ - _____ - _____

Relationship: _____ **E-mail address:** _____

MEDICAL HISTORY:

Preferred Pharmacy: _____ **Pharmacy Phone:** _____ - _____ - _____

Does this patient have a PCP? _____ **If so, name of PCP:** _____

MEDICAL INSURANCE:

Medicare ID: _____ **Secondary Insurance ID:** _____

Medicaid ID: _____ **Secondary Insurance ID:** _____

If not Medicare / Medicaid, name of insurance company: _____

Policy ID number: _____ **Group ID number:** _____

Name and DOB of the insured / policy holder: _____

PLEASE EMAIL a photo of the patient's insurance (both sides) and pt's drivers license or other state ID to: colemedical@icloud.com

For Office Use Only:

☐ Address Verified ☐ Insurance Verified ☐ Patient Scheduled ☐ MPOA Contacted ☐ CCM Eligible ☐ TCM Only