Intake Assessment Staff Associate: ____________

Equipment Requested: ____

Have you received this equipment before? Y: ____ Date: ______________ N: _____

Phone 1: _________________ Home Mobile Phone 2: _________________ Home Mobile

Email: ____

Last Name: ______________________________ First Name: __________________________

Permanent Address: ____

City: ____ State: __________ Zip: _____________

Local Address (If Different): ____

City: ____ State: __________ Zip: _____________

Alternate Contact Name (Required): ____

Relation: ____________________ Phone Number: _________________________

Primary Doctor Name: _______________________ Doctor Phone: _______________________

Primary Insurance: __________________________ ID: ________________________________

Secondary Insurance: ________________________ ID: _______________________________

Date of Birth: ________________________________ Height: ________ Weight: ___________

Diagnosis: ____________________ Male Female SSN #: __________________

Do you need the equipment requested due to the result of a fall? Y: N:

Do you have any visual, auditory, or verbal limitations? Y: __ Specify: ____________ N: __

POA (power of attorney) Y: N: Name: ________________________________
If yes, please provide a full copy of the power of attorney document.

I give permission for Health Aid Company, Inc. to leave messages concerning the requested medical equipment on the following: Phone 1 Phone 2

I declare that the information provided on this form is complete and correct and that I will notify Health Aid Company, Inc if any changes occur. I give Health Aid Company, Inc. permission to verify the information provided is correct.

Signature: ________________________________ Date: __________________________

Staff Info - In Stock: Y N Ordering Needed: Y N Drop Ship: Y N