BrickStreet
LONG TERM CARE

Patient Intake Form

Patient Name: _____ DOB: _____

Facility Name: _____

Address (including apt/room num): _____

Social #: _____ Medicare #: _____

(Attach a copy of any/all prescription insurance cards.)

Emergency Contact: _____

Relationship: _____ Phone: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Do you have Power of Attorney? Yes _____ No _____

(If Yes, Please attach a copy of the Power of Attorney.)

Drug Allergies:

_____

_____

Will medications be handled by the patient or the facility medication staff? _____

Current Pharmacy: _____

Phone: _____

Primary Care Physician(s): _____

Any and all information that has been provided above is kept confidential in accordance with all State, Federal, and local Laws relation to HIPPA and the protection of your identity.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the pharmacy; I understand that I am responsible for any balance. I also authorize BrickStreet LTC pharmacy or the insurance company to release any information required to process my claims.

_____

Patient/Representative's Signature Date

BrickStreet Long Term Care Pharmacy 312 W Rusk Street Suite B Tyler TX, 75701 (ph) 903-533-8155 (fax) 903-533-1020