Simms Homecare
and Behavioral Health Services
Capital Homecare

Patient Information

Patient Name: ______________________________ D.O.B.: __________

Address: ______________________________ Zip : ________ Phone: __________

Social Security #: ______________________________ Phone: __________

Emergency Contact: ______________________________

Relationship: ______________________________ Phone: __________

Allergies: ______________________________ Male / Female ______

Race American Indian Black/African American Hispanic/Latino Asian Caucasian

Marital Status Single Married Divorced Widow Separated S.O.

Physician Information

P. C. P.: ______________________________ Phone: __________

Address: ______________________________ Fax: __________

Discharge Date: ______________________________

Insurance Information

Medicare Medicaid CareSource CareStar Molina PASSPORT

Waiver Private Pay Workers' Comp Other ______________________________

Medicaid #: ______________________________ Medicare #: ______________________________

Policy #: ______________________________ Group #: ______________________________

Other Insurance #: ______________________________

Services Requested

Skilled Nursing PT/OT/ST Social Worker Home Health Aide

Referred By: ______________________________

Revised: Feb 2013