Comfort Care Medical Equipment
1105 N Point Blvd Ste 311, Baltimore, MD 21224
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customerservice@comfortcaremd.com

Patient Intake Form

Patient Information

Full Name _____ DOB _____ Gender _____

Address _____

City _____ State _____ ZIP _____

Mobile Phone _____ Billing Phone _____ Email _____

Emergency Contact

Name _____ Relationship _____ Phone _____

Primary Insurance

Insurance Provider _____ Medicare Primary? Yes / No _____

Policy Number _____ Group Number _____

Name of Insured _____ DOB of Insured _____ Benefits Phone _____

Secondary Insurance

Insurance Provider _____

Policy Number _____ Group Number _____

Name of Insured _____ DOB of Insured _____ Benefits Phone _____

Clinic Information

Therapist Name _____ Referring Clinic _____

Therapist Email _____

Products should be shipped to: ☐ Clinic ☐ Patient

Physician Information

Physician Name _____ Physician Phone _____

Physician Address _____ Physician Fax _____

Is a doctor's prescription already issued for the items requested? ☐ Yes ☐ No