American Medical
Rental & Supply

4358 South Washington. Tacoma, WA 98409 253-473-3055
1812 E. Main Street, Puyallup, WA 98372 253-848-1254

Client Intake Form

Who may we thank for referring you? _____
Date Completed: _____
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Client Name _____ Phone # (w/area code) _____
Street Address _____ DOB _____ Gender M ____ F____
City, State, Zip _____ Social Security # _____
Height (Inches) _____ Weight (lbs) _____

Contact Person: _____ Telephone # (w/area Code) _____
Street Address _____
City, State, Zip _____

Physician:
Name _____ Phone # (w/area code) _____
Facility Name _____ Fax # _____
Address _____ Specialty _____
City, State, Zip_____ Date Last Seen by this Physician: _____
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Insurance Information:
Name of Insurance _____ Insurance ID # _____
Insurance Address _____ Phone # (w/area code) _____
Subscriber/Insured Name _____ Date of Birth _____
Relationship to Insured: Spouse ____ Child ____ **Date of Birth**_____
Is the client's spouse employed? Yes __ No___

Other Insurance Information:
Name of Insurance _____ Insurance ID_____
Insurance Address _____ City, State, Zip _____
Phone # (w/area code) _____
Subscriber/Insured Name _____ Date of Birth _____
Name of Employer _____

Is the medical need for the equipment/supplies **due to employment**? Yes __ No ___
Date of Injury _____
Name & Address of Insurance
_____
_____
_____

Case # _____
Name of Case Mgr _____
Phone #_____
Fax # _____