Fax 1-732-960-3449 · Phone 732-444-8808
301 Lakehurst Rd, Suite 301, Toms River, NJ

New Patient Intake Form

Welcome to Infuse Care! Please take a minute to complete our secure intake form and consents. Fields marked * are required.

DEMOGRAPHIC INFORMATION

First name * _____ Middle name _____ Last name * _____

Date of birth * _____ Weight (lbs) * _____ Height (ft & in) * _____

Your current weight determines your dose for weight-based medications

Email * _____ Mobile number (text enabled) _____

Home phone (landline) _____ Employer * _____

Or self-employed, student, retired, on disability, or none

Street address * _____ Apt / Suite _____

City * _____ State * _____ Zip code * _____

Sex * _____ Gender pronouns _____ Gender identity _____

Sexual orientation _____ Race _____

Advance directive: Do you currently have an advance directive, such as a living will or durable power of attorney for healthcare? *

☐ Yes ☐ No

If yes, please provide a copy for your medical record.

How did you hear about Infuse Care? *

☐ Online search
☐ Doctor's office
☐ Pharmaceutical company
☐ Pharmacy
☐ Insurance company
☐ Friend / colleague / family (word of mouth)
☐ LinkedIn
☐ Facebook
☐ Blog post
☐ Television / news
☐ Drove by or walked by our center
☐ Event
☐ Organization / support group
☐ Other: _____

ID & INSURANCE INFORMATION

Please include copies with this form

Please provide a copy of the front and back of your insurance card(s) and your photo ID.

By submitting this form, I attest that I have provided all of my current medical and pharmacy insurance cards (e.g., Medicare Part B, Medicare Part D, Medicare supplement, commercial insurance) and copay program cards (if enrolled). I understand incomplete insurance information can cause delays in my treatment and higher out-of-pocket costs.

Copies included (front and back)

☐ **Primary medical and pharmacy insurance card(s)**
☐ **Secondary insurance card(s)**, if applicable
☐ **Photo ID** showing your photo and name (e.g., driver's license, badge)

Are you the subscriber on your primary insurance? *

☐ Yes, I am the owner of the insurance policy
☐ No, I am a dependent
☐ I don't have insurance

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MEDICAL INFORMATION

Have you received an infusion before? *

☐ Yes, I have received an infusion before ☐ No, I have never received an infusion

In the last 12 months, have you had a medication therapy management consultation with a pharmacist? *

☐ Yes ☐ No

Do you have concerns about COVID-19 exposure or protection due to a weakened immune system? *

☐ Yes ☐ No

Are you currently living at a facility that provides medical care and rehabilitation, like a skilled nursing or rehab facility? These are usually short-term stays after a hospital discharge. *

☐ Yes ☐ No

Do you currently have a Primary Care Physician (PCP)? *

☐ Yes ☐ No

Date of your last appointment with your PCP * _____

Date of your last appointment with the specialist who referred you * _____

COMMUNICATION PREFERENCES

Emergency contact name * _____ Phone * _____

Relationship * _____
Parent, spouse, guardian, etc.

Do you have a caregiver? Caregivers are family members, friends or neighbors who provide unpaid assistance to a person with a chronic illness or disabling condition. *

☐ Yes ☐ No

Preferred language *

☐ English ☐ Spanish ☐ French ☐ Other: _____

What communication / learning style works best for you? *

☐ Verbal ☐ Written ☐ Demonstration

Do you have any communication barriers we should be aware of? *

☐ Yes ☐ No

How often do you need help with reading or writing? *

☐ Always ☐ Sometimes ☐ Never

Please share any religious, cultural, or other preferences we should be aware of for your care: