



Metropolitan Area Consortium on House Call Medicine Provider Information Form

Please complete this form so that we may collect and share information about your practice with other consortium members. Return at consortium or fax to Maria Ortega at 212-426-5108.

First name: _____ **Last name:** _____ **Degree:** _____

Name of Program/Institution: _____

Phone: _____ **E-mail:** _____

Fax: _____ **Address:** _____

Are you currently making housecalls? YES NO

Are you in private practice? YES NO

Do you provide primary care services? YES NO If no, Specialty _____

Are you currently accepting new patients? YES NO

What is the current size of your practice's patient panel? _____

Geographic area served (please describe via zipcodes, boroughs, street borders): _____

Insurance accepted (circle all that apply): Medicare Medicaid None
Other: _____

Languages other than English spoken: _____

Specific health care interests: _____

Other comments: _____
