

Please contact my physician for the following services:

Diabetic Supplies Impotence Heat Lamp Heating Pad Uplift
Ankle/Foot Gauntlet

For Your Health Medical Supply

1- 800 -318-8466

P.O. BOX 194 MARSHALLS CREEK, PA 18335

DEAR PATIENT

PLEASE COMPLETE THIS FORM TO ASSURE THAT ALL THE INFORMATION WE TOOK OVER THE TELEPHONE IS CORRECT AND RETURN IT TO US IN THE ENCLOSED ENVELOPE. THANK YOU !

MEDICARE PATIENTS (HMO PATIENTS DO NOT QUALIFY):

NAME (AS IT APPEARS ON YOUR MEDICARE CARD) _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE (_____) _____ DATE OF BIRTH _____
HEIGHT _____ WEIGHT _____ SEX (CIRCLE ONE) MALE OR FEMALE
MEDICARE # (PRIMARY INSURANCE) _____ (INCLUDE LETTER: A,B,D,W, ETC.)
SUPPLEMENTAL INSURANCE _____
ADDRESS _____
PHONE(_____) _____ POLICY/ID # _____ GROUP# _____
PHYSICIAN'S NAME _____ PHONE(_____) _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____

PRIVATE INSURANCE PATIENTS (HMO PATIENTS DO NOT QUALIFY):

NAME (AS IT APPEARS ON YOUR CARD OR POLICY) _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE (_____) _____ DATE OF BIRTH _____
HEIGHT _____ WEIGHT _____ SEX (CIRCLE ONE) MALE or FEMALE
SOCIAL SECURITY # _____ EMPLOYER _____
INSURED'S NAME (IF NOT THE PATIENT) _____
DATE OF BIRTH _____ SOCIAL SECURITY _____ - _____ - _____
EMPLOYER _____
INSURANCE COMPANY _____ PHONE # (_____) _____ - _____
POLICY/ ID # _____ GROUP # _____
PHYSICIAN'S NAME _____ PHONE # (_____) _____ - _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____