We're so *swell* - you don't have to be
Compression *wear* it counts.
Specialists in Venous & Lymphatic Insufficiencies
LUNA MEDICAL, INC. · 4397 N. ELSTON AVE. CHICAGO, IL 60641
PHONE (800) 380-4339 · FAX (888) 696-0299 · WWW.LUNAMEDICAL.COM · INFO@LUNAMEDICAL.COM
ACCREDITED BY THE JOINT COMMISSION · OFFICIAL LANA SPONSOR

PATIENT DATA FORM

Patient Information:

First Name_____Middle Initial_____Last Name_____

Address_____Apt/Unit#_____

City_____State_____Zip_____

Phone (_____)_____Date of Birth_____/_____/ _____

Preferred Method of Contact:

It's imperative that we have a good phone number or email address to contact you when we receive measurements from your therapist. Your contact information is used solely for processing your orders. We review your insurance benefits, financial responsibilities and product orders with you before we proceed with order placement.

Email_____ **Phone (_____)**_____

Emergency Contact:

Name_____ **Relationship**_____**Phone (____)**_____

Ship Medical Products to: PLEASE CIRCLE Patient Lymphedema Clinic

Physician Information:

Referring Doctor_____Referring Doctor Phone (_____)_____
First Last

Primary Insurance Information:

Primary Insurance Name_____I.D.# _____

Benefits/Eligibility Phone (_____)_____

Name of Insured (policy holder)_____D.O.B. of Insured (policy holder)_____/_____/_____

Is Medicare the patient's Primary Insurance?_____Yes _____ No I.D.# _____

Secondary Insurance Information:

Primary Insurance Name_____I.D.# _____

Benefits/Eligibility Phone (_____)_____

Name of Insured (policy holder)_____D.O.B. of Insured (policy holder)_____/_____/_____

Completed by_____Date_____