We're so *swell* - you don't have to be
Compression *wear* it counts.
Specialists in Venous & Lymphatic Insufficiencies
LUNA MEDICAL, INC. · 1057 W GRAND AVENUE, SUITE 1, CHICAGO, IL 60642
PHONE (800) 380-4339 · FAX (888) 696-0299 · WWW.LUNAMEDICAL.COM · INFO@LUNAMEDICAL.COM
ACCREDITED BY THE JOINT COMMISSION · OFFICIAL LANA SPONSOR

PATIENT INTAKE FORM

Intake Order Taken By:_____ Date: _____
Referral Person calling in the order: _____ Telephone: _____

Patient Information: (PLEASE NOTE – THIS HAS TO BE YOUR PERMANENT ADDRESS)

First Name: _____ Middle Initial: ____ Last Name: _____ Date of Birth: _____
Address: _____ Apt/Unit# _____
City_____ State: _____ Zip:_____
Phone: (_____)_____ Email Address:_____

Preferred Method of Contact: (Please check one)

☐ **Email** ☐ **Home Phone** ☐ **Cell Phone** ☐ **Work Phone**

Ship Medical Products to: (Please check one)

☐ **Patient Home** ☐ **Lymphedema Clinic** ☐ **Other** _____

Physician/Nurse Practitioner Information: (PLEASE NOTE – THIS IS WHO PRESCRIBED OR REFERRED YOU TO THERAPY)

Ordering/Referring Doctor/ Nurse Practitioner: _____ NPI # _____
Telephone (_____)_____ Fax# (_____)_____
Address: _____ City_____ State_____ Zip code_____
Speciality: _____

Insurance Information: (PLEASE SEND FRONT AND BACK OF INSURANCE CARD AND A COPY OF YOUR ID)

Primary Insurance: _____
Primary Benefits/Eligibility Phone (_____)_____ POLICY ID# _____
Name of Insured (Policy Holder) _____ D.O.B. of Insured (Policy Holder) _____

Secondary Insurance: _____
Secondary Benefits/Eligibility Phone (_____)_____ POLICY ID# _____
Name of Insured (Policy Holder) _____ D.O.B. of Insured (Policy Holder) _____

Completed By: _____ **Date:** _____