Babette Maiss, CMT,CLT,CMF
Patient Information Sheet

(to be completed by patient on intake)

PATIENT INFORMATION Date: ______________

Name: ____

Address: ____

City____ State: ______ Zip: ___________________

Date of Birth: _______________________________ SSN (optional):____________________________

Daytime phone: ____________________________ Evening phone: _____________________________

Cell Phone: ____

Email: ____

Occupation____

PRIMARY CARE PHYSICIAN (PCP)

PCP Name: ____

Location/Hospital: ____

Phone Number: ____

EMERGENCY CONTACT

Name: ____

Relationship to Patient: ____

Phone Number: ____

INSURANCE INFORMATION

Please note that ____ is a private office which does not accept or file (submit) for insurance payment for services, lymphedema garments, bandage materials or L-Dex measuring. The following information is voluntary and for demographic purposes only.

Insurance Company: ____

Name of the Insured: ____

Relationship to Patient: ____

Patient ID Number: _______________________________ Group ID #:__________________________

Patient Signature: ____ Date: _____________________