Insurance Covered
COMPRESSION
THERAPY

Patient Intake Form

Phone 309-664-7930 • **Fax** 309-664-7931
Email orders@medsourceorders.com

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Can we text you on this phone number: ☐ Yes ☐ No

Preferred Contact Type: ☐ Phone ☐ Email ☐ Text

Doctor: _____ Doctor Phone: _____

Insurance: _____

Insurance Phone: _____

Insurance Policy/ID #: _____ Insurance Group #: _____

Secondary Insurance: _____

Insurance Phone: _____

Insurance Policy/ID #: _____ Insurance Group #: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Do you authorize anyone else to receive information about your care and/or medical billing information?

☐ Yes ☐ No If yes, who: _____

Patient Signature:_____ Date: _____