MIDWEST COMPRESSION
Pneumatic Compression Devices

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	Garment Set(s) Required
			Upper Extremity ☐ LEFT ☐ RIGHT
ADDRESS			Lower Extremity ☐ LEFT ☐ RIGHT
			Trunk ☐ ____ HEIGHT
CITY	STATE	ZIP	Chest ☐ ____ WEIGHT
			Head and Neck ☐

HOME PHONE	MOBILE PHONE	WORK PHONE

EMAIL	DATE OF BIRTH	GENDER
		☐ Female ☐ Male

EMPLOYER	EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE

HOW DID YOU HEAR ABOUT US?

☐ Physician ☐ Therapist ☐ Internet ☐ Friend ☐ Advertisement ☐ Other:

INSURANCE INFORMATION

TYPE OF INSURANCE
PLEASE CHECK ☐ **Private Health Insurance** ☐ **Workers' Comp** ☐ **Medicare** ☐ **Medicaid** ☐ **Self-Pay**

DATE OF INJURY IF WORKERS' COMP	WORKERS' COMP CLAIM NUMBER

PRIMARY INSURANCE COMPANY	PHONE NUMBER

NAME OF POLICY HOLDER	PATIENT'S RELATIONSHIP TO POLICY HOLDER
	☐ Self ☐ Spouse ☐ Child ☐ Other
DATE OF BIRTH OF POLICY HOLDER	EMPLOYER
IDENTIFICATION NUMBER	GROUP NUMBER

SECONDARY INSURANCE COMPANY	PHONE NUMBER

NAME OF POLICY HOLDER	DATE OF BIRTH OF POLICY HOLDER	PATIENT'S RELATIONSHIP TO POLICY HOLDER
		☐ Self ☐ Spouse ☐ Child ☐ Other
IDENTIFICATION NUMBER		GROUP NUMBER

PRESCRIBER INFORMATION

PRESCRIBER'S NAME	NPI (NATIONAL PROVIDER NUMBER)
CLINIC NAME	PHONE / FAX
ADDRESS	CITY / STATE / ZIP

THERAPIST INFORMATION

THERAPIST'S NAME	
WORK EMAIL APPROVED TO EMAIL DOCUMENTS ☐ Yes ☐ No	
PHONE	FAX

FACILITY/CLINIC INFORMATION

FACILITY/CLINIC NAME		
ADDRESS		
CITY	STATE	ZIP

MIDWEST COMPRESSION
EMAIL:
info@midwestcompression.com
FAX: 800.886.4201