Enrollment and Patient Consent Form

(Patient Consent Form located on next page)

Personal Information:

Full Name: _____
as it appears on your Medicare Card

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone #: (____) _____ Other Phone #: (____) _____

Email: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Preferred method of contact: ☐ Email ☐ Phone ☐ Text

Would you like to be added to our contact list for reorder reminders? ☐ Yes ☐ No

Insurance Information:

Medicare Beneficiary ID (MBI) _____ Is this a Medicare Advantage? ☐ Yes ☐ No

Secondary/Other Insurance Information:

Name of policy: _____ Phone #: (____) _____

Member ID: _____

***Please provide front and back copies of your insurance cards upon enrollment.**

Medical Information:

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: (____) _____ Approximate date of last visit: _____

Do you have a Colostomy? ☐ **Yes** ☐ **No** **Are you a Urological Customer?** ☐ **Yes** ☐ **No**

Ileostomy? ☐ **Yes** ☐ **No**

Urostomy? ☐ **Yes** ☐ **No**

What products do you use? _____

_____

_____