Enrollment Form – Patient Information

Please print. Thank you for choosing Healthy Living Diabetic

Please check the services you are interested in.

☐ Diabetic Supplies ☐ Prescription Medication ☐ Incontinence

PERSONAL INFORMATION:

Name: ____________________

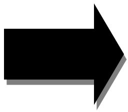
Address: ____________________

City: ____________________

Home Phone: (____) _____-_______ Other Phone: (____) ____-_______ Email: ____________________

Social Security #: ______-______-______ Date of Birth: ______/______/______ Sex: ______ Marital Status: ____________________

Next of Kin: ____________________ Emergency Phone #: (______) _______-____________________



By signing this form you are authorizing Healthy Living Diabetic, its affiliates, subsidiaries or parent company to contact you by telephone.

INSURANCE INFORMATION:

Medicare #: ____________________ Part B Effective Date: _____/_____/________

Medicare Prescription Drug Plan Name: ____________________ Part D Plan #: ____________________

Name of Secondary or Primary Commercial Insurance: ____________________

Insurance Phone #: (_____)______-_______ Policy or ID #: ____________________ Group #: ____________________

Name of Policyholder (if not patient): ____________________

Policyholder's Date of Birth: _______/_______/________ Policyholder's SS #: ________-________-__________________

Employer's Name: ____________________

City: ____________________ State: _________ Zip Code: ______________

MEDICAL INFORMATION:

Physician's Name: ____________________

Address: ____________________

City: ____________________ State: _________ Zip Code: ______________

Phone #: (____) ______-________ Appointment Date of Last Visit: ______/______/________

REFERRING AGENCY

Contact Person: ____________________ Phone: (_____)______ -_______ Ext:___________

healthy living diabetic

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