I understand a 1 1/2% (18% APR) service charge will be applied to account balances 30 days after payment, or determination of benefits, has been received from any insurance carrier.

I understand that adjustments to the appliance will be made at no charge for 90 days following delivery and that any defective component parts will be replaced as allowed by the original manufacturer's warranty. No other guarantees are expressed or implied.

PLEASE PRINT TODAY'S DATE_____

PATIENT INFORMATION

PATIENTS LAST NAME		FIRST NAME		M.I.
STREET ADDRESS APT #		CITY	STATE	ZIP CODE
HOME PHONE	EMPLOYER	WORK PHONE	DIAGNOSIS	
BIRTH DATE	SOCIAL SECURITY NUMBER	SEX	DOCTOR'S NAME	
EMERGENCY NAME		RELATIONSHIP	PHONE	
INSURANCE SUBSCRIBER NAME		RELATIONSHIP TO PATIENT	SUBSCRIBER DOB	

GUARANTOR (RESPONSIBLE PARTY)

NAME	RELATIONSHIP TO PATIENT		PHONE NUMBER
STREET ADDRESS APT #		CITY	
STATE	ZIP CODE	EMPLOYER	WORK PHONE NUMBER

INSURANCE INFORMATION

TYPE OF INSURANCE

❑ MEDICARE ❑ MEDICAL ASSISTANCE ❑ WORKER'S COMPENSATION ❑ PRIVATE POLICY ❑ NO INSURANCE

MEDICARE NUMBER	MEDICAL ASSISTANCE NUMBER

PRIMARY AND SECONDARY INSURANCE INFORMATION

PRIMARY CARRIER NAME	NAME OF POLICY HOLDER		
PRIMARY CARRIER MAILING STREET ADDRESS	CITY	STATE	ZIP
PRIMARY CARRIER CONTACT NAME	CONTACT TELEPHONE NUMBER		
PRIMARY CARRIER POLICY NUMBER	PRIMARY CARRIER GROUP NUMBER		
RELATIONSHIP OF POLICY HOLDER TO PATIENT ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER	EFFECTIVE DATE OF INSURANCE		
SECONDARY CARRIER NAME	NAME OF POLICY HOLDER		
SECONDARY CARRIER MAILING STREET ADDRESS	CITY	STATE	ZIP
SECONDARY CARRIER CONTACT NAME	CONTACT TELEPHONE NUMBER		
SECONDARY CARRIER POLICY NUMBER	SECONDARY CARRIER GROUP NUMBER		
RELATIONSHIP OF POLICY HOLDER TO PATIENT ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER	EFFECTIVE DATE OF INSURANCE		

PRIMARY AND SECONDARY INSURANCE INFORMATION

EMPLOYER'S NAME			EMPLOYER'S INSURANCE COMPANY		
EMPLOYER'S ADDRESS			INSURANCE COMPANY STREET ADDRESS		
EMPLOYER'S CITY	STATE	ZIP	INSURANCE COMPANY CITY	STATE	ZIP
CLAIMS CONTACT NAME A ND PHONE NUMBER			POLICY NUMBER	CLAIM NUMBER	DATE OF INJURY