



CUSTOMER INFORMATION

Fill out this form and bring it with you to help expedite your next visit to our office.

Date _____

Name _____

Date of Birth _____

Do you have an Infectious Disease Yes No

If Yes explain: _____

Advanced Directives? Yes No

Notes: _____

Have you been here before? Yes No

Address changed? Yes No

Phone number changed? Yes No

Insurance changed? Yes No

Who are you here to see?

- _____ Respiratory
- _____ Customer Service
- _____ Rehab
- _____ Service
- _____ Respiratory Repair

How did you hear about us?

- _____ Physician _____ TV
- _____ Friend/Relative _____ Newspaper/Magazine
- _____ Radio _____ Other: _____

RMS Initial _____

Please enter current information below

Address _____ City _____ State _____

Zip Code _____ Phone (_____) _____

Primary Insurance Carrier _____ Secondary Insurance Carrier _____

Group # _____ ID # _____ Group # _____ ID # _____