Renua Medical (a Health First Technologies Company)
NeuroCare Patient Intake Information

____ DOB: ___ / ___ / ___ SEX: ____ Male ____ Female
PATIENT NAME (FRIST, MIDDLE INITIAL,LAST)

____ _______________________________
RESPONSIBLE PARTY'S NAME (if different from above) SOCIAL SECURITY#

____ ____
ADDRESS DRIVER'S LICENSE # STATE PHONE #

____ ____
CITY STATE ZIP CREDIT CARD # EXP. DATE Security Code

EMPLOYER'S NAME: ___________________________________EMPLOYER'S PHONE #:__________________________

How did the patient hear about NeuroCare? ____

Who first introduced the patient to NeuroCare Therapy? ____

DIAGNOSIS: (ICD-9 CODE) ____

IS THIS CLAIM THE RESULT OF AN ACCIDENT? YES ___ NO ___

TYPE OF INJURY: ____ WORKER'S COMP: ____ AUTO: ____ SPORTS: ____ OTHER: ________________________________

DATE OF INJURY ___ / ___ / ___ CLAIM # ______________________ CLAIM ADJUSTER: ___________________________

The Patient has been informed that it is their responsibility to obtain coverage for the use of the equipment from their own insurance provider*:* ___ Y ___ N

(Optional) INSURANCE COMPANY: ____

ADDRESS: ____

PHONE **#:** ____________________________ POLICY # ______________________ GROUP # ______________________

POLICY HOLDER'S NAME (if different than patient): ____

REFERRING PHYSICIAN: ____ PHONE #: ___________________________

PRACTITIONER: ____ PHONE #: ___________________________

ORDER FOR EQUIPMENT FROM LICENSED PRACTITIONER ATTACHED? YES ___ NO ___

Do you have any of the following conditions? If the answer to any of the following questions is yes, your physician will explain treatment precautions and why treatment is indicated. Women who are not sure if they are pregnant must get a pregnancy test.

	YES	NO		YES	NO
An Implanted Pacemaker	___	___	Are you pregnant?	___	___
Thrombosis-Phlebitis	___	___	Are you under treatment for any acute problem?	___	___
Epilepsy	___	___	Are you suffering from any other chronic muscle		
Cancerous Lesions	___	___	or nerve Disorder?	___	___
Varicose Veins	___	___	If "YES" please describe below:		

____

Patient agrees to only use the equipment in the manner and for the person for whom the unit is prescribed or ordered.

____ ___________________________
Patient's SIGNATURE) Print Name DATE

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