smartvest®
AIRWAY CLEARANCE SYSTEM

PATIENT DEMOGRAPHICS FORM

INSTRUCTIONS
When complete please **fax** directly to Electromed, Inc. at **866-758-5077.** Please attach **signed Patient Agreement Form.** Questions? Please call **Electromed, Inc.** at 800-462-1045**.**

PATIENT INFORMATION

Name: (Last) _____ (First)_____ (Middle Initial)_____

Street Address:_____

City:_____ State:_____ Zip code:_____

Evening Phone:_____ Daytime Phone:_____ Cellular:_____

Date of Birth:_____ SS#:_____ M☐ F☐

Guardian/relationship:_____

Primary DX code:_____ Primary Diagnosis:_____

Secondary DX Code:_____ Secondary Diagnosis:_____

INSURANCE INFORMATION - Will accept printout of insurance information

Primary Insurer:_____ Telephone #:_____

ID #:_____ Group #:_____

Insured:_____ Insured's DOB:_____ Relationship to insured:_____

Secondary Insurer:_____ Telephone:_____

ID #:_____ Group #:_____

Insured:_____ Insured's DOB:_____ Relationship to insured:_____

HEALTHCARE TEAM (including **PRESCRIBING PHYSICIAN)**

Clinic Name:_____ Clinic Telephone #:_____

Clinic Address: _____

Clinic City:_____ State:_____ Zip code:_____

Clinic Contact Name:_____ Contact telephone #:_____

Clinic Contact E-mail:_____ Clinic Fax #:_____

Physician Name:_____ Physician NPI:_____

Corporate Headquarters
500 Sixth Ave. N.W.
New Prague, MN 56071
Phone: 952-758-9299
Fax: 866-758-5077
www.smartvest.com