Patient Information Form

(required for the Pelvic Floor Electrical Stimulator System E0740)

Please complete this form and fax to Current Technology, Inc. at 763-588-0066

If you have any questions, please call us at 800-322-4461

NOTE: A Copy of All Pertinent Medical Records must accompany this form

(Required for Insurance Reimbursement)

Physician Information:

Physician's Name:	Physician's phone:
Physician's Address:	Physician's fax:
NPI:	Diagnosis: N39.46 urge incontinence N39.3 stress incontinence (female)(male) N39.46 mixed incontinence (female) (male) R15.9 Full incontinence of feces (PLEASE CIRCLE) Other: _____

Patient Information:

Patient Name:	Date of Birth:
Street Address:	Social Security Number:
City, State & Zip Code:	
Home phone:	Cell phone:
Name of Spouse:	Emergency Contact / Telephone Number:
Employer:	Business Telephone:
Onset of Symptoms:	**Previously owned Pelvic Floor Stimulator:** YES NO If YES when:
Medications/Treatments:	

Medicare Information:

Primary Insurance:	Insurance Co. phone:
ID/Policy #:	Group #:

Supplemental Insurance Information:

Secondary Insurance Co.:	Secondary Insurance Co. Phone:
Secondary Insurance ID #:	Secondary Insurance Group #:
Subscriber Name:	Subscriber Date of Birth:
Subscriber Social Security Number:	Subscriber Employer:

Patient's Signature_____Date_____

I am responsible for payment of purchase fees that are not paid for or declined for payment by my insurance carrier. If I cannot meet this financial obligation, I will contact S.A. Maher, Inc. at 440-777-5544. I request that my payment from my Medical Insurance Program be made directly to: **S.A. MAHER INC., P.O. BOX 38306 OLMSTED FALLS, OHIO 44138.** I authorize release of medical information when needed. I understand the charge for a Pelvic Floor Stimulation Unit and Sensor is $595.00.