

# NEW PATIENT ENROLLMENT FORM

## Diabetics Testing Supplies

## Home Delivery Program

### PERSONAL INFORMATION

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Other Phone #: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Emergency Phone #: \_\_\_\_\_

Signature: \_\_\_\_\_

By signing, you are authorizing Medico Express to contact you by telephone

### INSURANCE INFORMATION

Medicare #: \_\_\_\_\_ Part B Effective Date: \_\_\_\_\_

Name of Secondary Insurance: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_ Policy or ID: \_\_\_\_\_ Group: \_\_\_\_\_

### MEDICAL INFORMATION

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone # \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

### REFERRING AGENCY INFORMATION

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PLEASE FAX COMPLETED FORM TO 1-800-000-0000



4770 Biscayne Blvd., Suite 780  
Miami, Florida 33137  
Phone: 305-576-7555

**Note:** Within 24 hours, a Medico Express enrollment specialist will contact the patient to complete the enrollment process.