

ORDER FORM
NEW PATIENT
CUSTOM PRESSURE GARMENTS



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BCI_39294

Bio-Concepts
Use Only

CIRCLE ITEMS ORDERED



SUBMIT THIS FORM ONLY WITH MEASUREMENTS FOR A NEW PATIENT

SHIP TO Patient Facility Attention _____ **Need By** _____

ORDER DATE _____ Shipping Method _____
First Class Mail - U.S. & Canada is standard (and free).

REQUIRED PATIENT INFORMATION

Age _____ Sex _____

Last Name _____ First Name _____

IS THIS A BURN PATIENT? Yes No Edema Traumatic Scar Lymphedema

Desired Pressure: _____ mmHg Other: _____

IF SHIPPING TO PATIENT

Telephone No. _____ Address _____

FACILITY INFORMATION

Purchase Order # _____ Measured by _____

Billing Contact _____

Billing Telephone _____ Quickest way to contact you: Telephone/Pager/Fax/Email

Facility Name _____

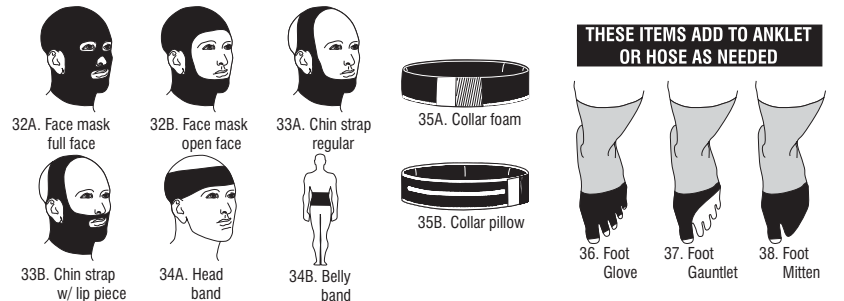
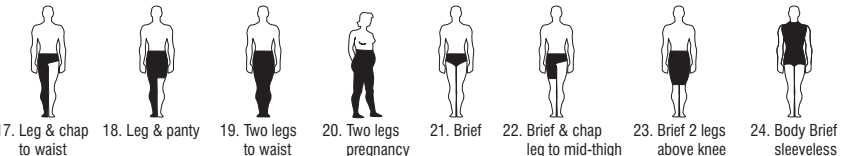
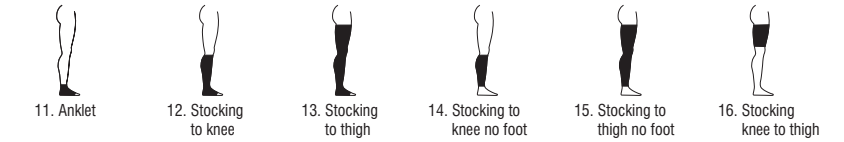
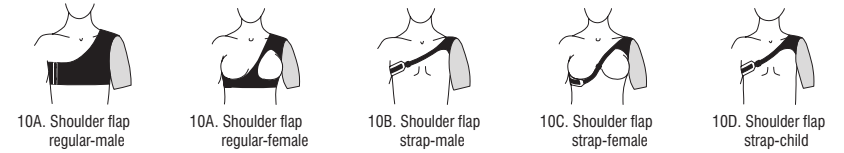
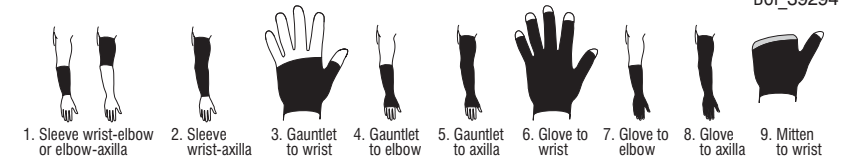
SHIP TO Address _____ **BILL TO** Address _____

IF BILLING INSURANCE/WORKMAN'S COMP/HEALTH PLAN

NOTE: This information is only needed if we are to bill patient's health plan. Attach a copy of the prescription and, if available, a copy of the hospital face sheet. Additional information may be needed.

Patient Date of Birth _____ Date of Injury _____

Insurance Carrier _____ Insurance Telephone _____



THESE ITEMS ADD TO ANKLET OR HOSE AS NEEDED

BIO-CONCEPTS USE ONLY
(Please write nothing in this block)