PATIENT INFORMATION FORM Date _____/_____/_____

Patient Name _____ Nickname_____ DOB _____/_____/_____

Address _____ Social Security # _____-_____-_____

City _____ State _____ Zip _____ Marital Status S__ M__ Other ____

Home Phone (_____)_____ Cell (_____)_____ Other (_____)_____

Doctor Name_____ Phone (_____)_____ Fax(_____)_____

Primary Insurance _____ Subscriber Name _____

ID#_____ Group#_____ Subscriber DOB _____/_____/_____

Insurance Co. Address _____

City _____ State _____ Zip _____ Phone (_____)_____

Secondary Insurance _____ Subscriber Name _____

ID#_____ Group#_____ Subscriber DOB _____/_____/_____

Insurance Co. Address _____

City _____ State _____ Zip _____ Phone (_____)_____

Surgery Information

Date of Surgery _____/_____/_____ Type: Mastectomy____ Partial Mastectomy____ Other _____

Surgery/Affected side: Left____ Right____ Bilateral____ Other _____

Lymph Nodes removed____ # of nodes____ History of Lymphedema____ Treated for Lymphedema____

Type _____ Chemotherapy ____ Radiation ____ Reconstruction_____

Visible scars, rashes, open wounds, excessive tissue _____