Patient's Name

_____

Address

_____

City

_____ State _____ Zip _____

Day Phone _____Evening Phone _____

E-mail _____Fax _____

Method of Payment:

Check Enclosed (US Currency Only)_____ Master Card_____ Visa_____

Card # _____Exp. Date_____

Name on Credit Card_____

Credit Card Billing Address _____

City _____ State _____ Zip _____

Signature _____

Name of your licensed health care provider _____

License # _____

Dr's address _____

City _____State _____Zip _____

Diagnosis code _____

Doctor's Phone Number _____

Doctor's Signature _____

Print out (CTRL P TO PRINT) and mail or fax form to
Pain Management Technologies, Inc.
1340 Home Avenue, Building A
Akron, OH 44310
FAX: 888-304-5454