Medicare Patient Information Form

Name:_____
__
Home Phone:_____Work Phone:_____Cell Phone
_____
Email
Address:_____
Home Address: _____City:_____Zip
Code:_____
Spouse's Name:_____Work
Phone:_____
Social Security #:_____Date of
Birth:_____
Nearest Relative not living with
you:_____Phone:_____
Nearest friend not living with
you:_____Phone:_____
Primary Care or Referring
Physician_____Phone:_____
Whom may we contact in the case of an emergency?
_____Phone:_____
Whom may we thank for referring you to us?
_____Phone:_____

Did you sustain an injury at work? Y N

Are you covered under an employer or union policy? Y N

Are your injuries accident related? Y N

Is your spouse or other family member employed? Y N

Are you currently employed? Y N

Do you have a secondary insurance policy? Y N

Have you ever served in the military? Y N

Are you covered under any other health care plan? Y N

Have you made any changes to your choice of Medicare options in the last open enrollment period? Y N

I am a new patient to this practice and am in a preexisting provision with my insurance carrier. Y N

Who is responsible for this bill?

If I have received services by another provider for the condition for which I seek treatment today, then I will promptly disclose any necessary information to my insurance carrier necessary to resolve any issues they may have. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this

information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature:_____Date:_____