PLEASE FILL OUT THIS FORM COMPLETELY

THE MORE INFORMATION THAT YOU PROVIDE US WILL HELP TO MAKE YOUR CHECK IN FASTER AND MORE EFFICIENT

PLEASE BE PREPARED TO PROVIDE INSURANCE CARDS AND IDENTIFICATION

PATIENT NAME _____ SSN _____--_____--_____
ADDRESS_____
CITY_____STATE_____ZIP_____PHONE_____
EMAIL_____ CELL PHONE_____
DOB_____-_____-_____ MARITAL STATUS _____ RACE _____ DR _____
EMPLOYER_____ PHONE_____

IF YOU ARE NOT THE POLICY HOLDER-

INSUREDS NAME _____ DOB_____-_____-_____
DATE OF PROCEDURE____--____--_____ALLERGIES___DIABETIC___PREG___
IS THIS VIST RELATED TO A WORKERS COMP CLAIM? ____YES ____NO
IS THIS RELATED TO AN ACCIDENT? ___YES ____NO
DATE OF ACCIDENT _____--____--_____LOCATION_____TIME_____

MEDICARE QUSTIONNAIRE

1) Are you receiving Black Lung Benefits? Y N
2) Are the services to be paid by a government program such as a research grant? Y N
3) Has the Dept of Veteran Affairs (DVA) authorized and agreed to pay for care at this facility? Y N
4) Was the illness/injury due to a work related accident? Y N
   If yes, the date_____
5) Was the illness/injury related to a non-work related accident? Y N
   If yes, the date_____ Please circle: Automobile or Other
   Insurance coverage for Automobile Accident: _____
6) Are you entitled to Medicare based on: ___Age ____Disability ____ESRD
7) Are you currently employed? Y N
8) Is your spouse currently employed? Y N
   If no: ____ Retired or _____ Not Married
   If no or retired, date of retirement
9) Do you have insurance coverage based on your own or a spouses' current employment? Y N