Medicare Patient Questionnaire

Patient Name: ___________________________________ Date of Birth: ____________________

Today's Date: ____________________________________ Phone: __________________________

1. Are you entitled to Medicare based on: (please check one)
   □ Age □ Disability □ End Stage Renal Disease (ESRD)

2. Are you currently employed? □ Yes □ No (Retirement Date: ______________________)
   If Yes, please complete the following:
   Employer Name: ____
   Employer Address: ____
   Employer Phone Number: ____

3. Is your spouse currently employed? □ Yes □ No
   If Yes, please complete the following:
   Employer Name: ____
   Employer Address: ____
   Employer Phone Number: ____

4. Do you have health insurance based upon your own, or your spouse's current employment?
   □ Yes □ No

5. Are you receiving Black Lung Benefits? □ Yes □ No

6. Was your injury/illness caused by an automobile accident? □ Yes □ No
   If Yes, please complete the following:
   Insurance Co.: ____
   Address: ____
   Claim #: _________________________ Claims Adjustor: _______________________________

7. Was your injury/illness caused by an accident other than an automobile accident?
   □ Yes □ No
   If yes, is another party responsible for your medical bills?
   □ Yes □ No
   If Yes, please briefly explain situation:
   ____
   ____
   ____

I hereby certify that all statements and answers provided by me in this questionnaire are true to the best of my knowledge:

Patient Signature: ____ Date: _______________