

PATIENT DATA SHEET (Medicare)

Today's Date _____

Single () Married () Divorced () Separated () Widow(er) () Disabled ()

Patient's Name _____
Last First Initial Birth Date

Home Address _____
Home Phone _____
City State Zip Code

Patient Social Security # _____

We need to know if you are currently employed or if your spouse is currently employed. Please indicate below:

YOU - Yes* () No () **SPOUSE** - Yes*() No ()

***If you have answered Yes for you or you spouse please complete the back of this page.**

Are you allergic to any medications? Please list: _____

Who referred you to our office? _____

Please give us the name and address of a close relative, friend or neighbor whom we could contact in case of emergency, changes, etc. if you are unavailable:

Name: _____ Relationship: _____

Address: _____ Telephone: _____

SPOUSE INFORMATION

Name _____ Birth Date _____ Social Security # _____

INSURANCE INFORMATION

Do you have Medicare Part B Coverage? YES _____ NO* _____

***If you do not pay for Medicare Part B coverage, you are responsible for all of our charges.**

Medicare Number: _____ Is Medicare Primary? _____ *

***If you have answered NO to Medicare primary please complete back of this page.**

Do you have a Medicare supplement insurance? YES _____ NO _____ **

****Medicare pays only 80% of their approved fees, the patient is responsible for payment of the remaining 20% at the time of service if there is no supplemental insurance.**

Please give us information about your supplemental insurance:

Insurance Company Name: _____

Address for Claims Submission: _____

Your Policy or Member Identification Number: _____

FINANCIAL RESPONSIBILITY

All services are billed to Indiana Medicare Part B. The patient is responsible for Medicare Part B deductible and any coinsurance amounts not covered by a supplemental policy. If the patient belongs to a Medicare HMO or alternative Medicare policy in which we are not a participating provider, they will be considered a self-pay patient and will be directly responsible for our standard non-Medicare charges. Payment for these charges will be expected at the time of service.

Patient Signature: _____ Date: _____

