Medicare Patient Information Form

Name: ____________________ Birthdate: ________
Social Security Number: ______________________
Home Phone: __________________________________
Cell Phone: ___________________________________
Spouse Name: _________________________________
Nearest relative not living with you: __________
Phone number: _________________________________
Who is responsible for this bill (other than insurance):
____

Did you sustain an injury while at work? ___________________
Are your injuries accident related? ________________________

I will be paying today by cash ___ check ___ credit card_____

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 all sheets and have completed the 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