SONORAN ORTHOPAEDIC TRAUMA SURGEONS

Medicare Patient Information

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: _____

Doctor: _____ 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

Are you enrolled in a Medicare Advantage Plan?

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? _____

I have received services by another provider for the condition for which I seek treatment today and 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: _____