CHI Memorial
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158572

FACE SHEET
PATIENT INFORMATION & MEDICARE QUESTIONNAIRE

Patient Identification

Have you been a patient before? ☐ Yes ☐ No

NAME:_____Social Security #:_____

DOB:_____ Age:_____ Sex:_____ Home Ph #:_____ Cell Ph #:_____

Address:_____
Street/Apt. # City State Zip Code

P.O. Box:_____ E-mail address:_____

Marital Status: ☐ S ☐ M ☐ W Race:_____ Religion:_____

Church Affiliation:_____

Patient's Employer:_____

Address:_____
Street/Apt. # City State Zip Code

Phone #:_____

Occupation:_____

Next of Kin:_____ Relationship to Patient:_____

Address:_____
Street/Apt. # City State Zip Code

Phone #:_____ Work #:_____

Emergency Contact:_____ Contact's Relation:_____

Address:_____
Street/Apt. # City State Zip Code

Phone #:_____ Work #:_____

Guarantor:_____ Social Security #:_____

Guarantor's Employer:_____

Address:_____ P.O. Box:_____
Street/Apt. # City State Zip Code

Insurance #1:_____ ID#:_____ Group #:_____

*Subscriber Name:*_____ *DOB:*_____ *SS#:*_____

Employer:_____ Company insurance is with:_____

Insurance #2:_____ ID#:_____ Group #:_____

*Subscriber Name:*_____ *DOB:*_____ *SS#:*_____

Employer:_____ Company insurance is with:_____

PCP:_____ Ordering Physician:_____

Reason for visit:_____

Was this an accident? ☐ Yes ☐ No Date of accident:_____

Type:_____

Location:_____

MEDICARE PATIENTS SEE BACK

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Patient Identification

Medicare needs your help by answering the following questions:

1. What is the date of your last hospitalization? ____/____/_____
2. Are you enrolled in a Medicare HMO? **Y N**
3. Are you covered by Black Lung or a government program such as a research grant? **Y N**
   If yes, please enter the begin date: ____/____/_____
4. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? **Y N**
5. Is today's visit related to a Workers' Compensation claim or any other type of accident? **Y N**
   If yes, please enter the date of accident ____/____/_____ and select below what type of accident this is related to.
   - ☐ Workers' Compensation ☐ Auto
   - ☐ Home ☐ Other

   Please provide the Workers' Compensation or liability insurance information below:
   - Name of Carrier: _____
   - Claim Number: _____
   - Address for claims: _____
   - Adjuster name/number: _____
6. What is your entitlement reason for Medicare?
   - ☐ Age
   - ☐ Disability
   - ☐ ESRD (End Stage Renal Disease)
7. Are you and/or your spouse still employed?

YES Patient Employer	**YES** Spouse Employer
_____	_____
_____	_____
_____	_____

NO Patient retirement or disability date:	**NO** Spouse retirement or disability date:
____/____/_____	____/____/_____

8. Do you or your spouse have insurance through either of your employers? **Y N**
9. Does you or your spouse's employer employ:
   - ☐ 20 or more employees **Y N**
   - ☐ 100 or more employees **Y N**

Please only complete the following questions if you receive your Medicare based <u>on End Stage Renal Disease</u>:

1. Have you received a kidney transplant? **Y N**
   Date of transplant: ____/____/_____
2. Have you received maintenance dialysis treatments? **Y N**
   Date dialysis began: ____/____/_____
3. If you participate in a self-dialysis training program, provide date training started:
   Date training started: ____/____/_____
4. Are you within your 30-month coordination period? **Y N**