CHI Memorial
Imagine better health.℠

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**