



## Medicare Patient Questionnaire

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Today's Date:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

I. Are you entitled to Medicare based on: (please check one)  
 **Age**       **Disability**       **End Stage Renal Disease (ESRD)**

II. Are you currently employed?  
 **YES**       **NO** (Retirement Date: \_\_\_\_\_)

**If YES, please complete the following:**

**Employer Name:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_

**Employer Phone Number:** \_\_\_\_\_

III. Is your spouse currently employed?  
 **YES**       **NO**

**If YES, please complete the following:**

**Employer Name:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_

**Employer Phone Number:** \_\_\_\_\_

IV. Do you have health insurance based upon your own, or your spouse's current employment?  
 **YES**       **NO**

V. Are you receiving Black Lung Benefits?  
 **YES**       **NO**

VI. Was your injury/illness caused by an automobile accident?  
 **YES**       **NO**

**If Yes,**

**Insurance Co.:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Claim #:** \_\_\_\_\_ **Claim Adjustor:** \_\_\_\_\_

VII. Was your injury/illness caused by an accident other than an automobile accident?  
 **YES**       **NO**

**If yes, is another party responsible for your medical bills?**

**YES**       **NO**

**If YES, please briefly explain situation:**