

MEDICARE QUESTIONNAIRE

HOME HEALTH/SKILLED NURSING FACILITY

Are you currently enrolled in home health care? YES NO

Are you enrolled in a skilled nursing facility (nursing home/rehab) YES NO

Name of nursing facility or home health agency: _____

Telephone number of nursing facility or home health agency: _____

Start date of home health: _____

Admit date to skilled nursing facility: _____

Have you been discharged? YES NO If yes, discharge date: _____

AUTO ACCIDENT

Was this injury due to an automobile accident? YES NO

If yes, date of accident: _____

State in which accident occurred: _____

Name of insurance company: _____

Telephone number of insurance company: _____

Agent or contact person: _____

Are you (or your spouse) the guarantor on insurance information listed above? YES NO

If no, please list guarantor: _____

Patient's Name _____ Account Number _____

Today's Date _____ Patient's Signature _____