

Insurance Questionnaire

The following questions are necessary so that we may properly file your insurance for you. These questions are taken directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.

1. Insured's ID Number _____
2. Patient Name: _____
3. Insured's Name (as it appears on the insurance card): _____
4. Patient's Address: _____
City _____ State _____ Zip _____ Tel # _____
5. Insured's Address (if same as patient put "same"): _____
City _____ State _____ Zip _____ Tel # _____
6. Patient Status (circle one): Single Married Other Employed Full-time Student Part-time Student
7. Other Insured's Name (if applicable): _____
Other Insured's Policy or Group Number: _____
Other Insured's Date of Birth: _____ Male _____ Female _____
Employer's Name or School Name: _____
Insurance Plan Name or Program Name: _____
8. Is the condition we are treating related to current or previous employment? Yes ___ No ___
9. Is the condition we are treating related to an auto accident? Yes ___ No ___
10. Is the condition we are treating related to another type of accident? Yes ___ No ___
11. Insured's Policy Group or FECA Number: _____
Insured's Date of Birth: _____ Male _____ Female _____
Employer Name or School Name: _____
Insurance Plan Name or Program Name: _____
12. Is there another health benefit plan? Yes ___ No ___

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed: _____ Date: _____

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to Paul Chiropractic for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed: _____ Date: _____

MEDICARE ONLY

All doctors have been instructed to ask the following questions of all Medicare patients.

1. Do you or your spouse work for a company that provides you with health insurance? Yes ___ No ___
2. Are you entitled to Medicare because of End Stage Renal Disease? Yes ___ No ___
3. Is the illness or injury the result of an accident or illness that occurred at work? Yes ___ No ___
4. Is this illness or injury the result of an accident or other injury? Yes ___ No ___
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes ___ No ___
6. Are you entitled to any benefits under the Federal Black Lung Program? Yes ___ No ___
7. Do you have a Medicare Medigap Policy? Yes ___ No ___ Name of Company _____
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from)? Yes ___ No ___