CYPRESS
PHYSICAL THERAPY

Medicare Patient Information

Date: _____ Patient Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Home Address: _____ City, State: _____ Zip Code: _____

Social Security Number: _____ Date of Birth: _____

Spouses Name (if applicable): _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

Nearest Relative Not Living With You: _____ Phone: _____

Nearest Relative Not Living With You: _____ Phone: _____

Nearest Relative Not Living With You: _____ Phone: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Who is responsible for this bill? _____

Did you sustain this injury at work?	Y	N	Are you covered under any other healthcare plan?	Y	N
Are the injuries accident related?	Y	N	Is your spouse or other family member employed?	Y	N
Are you currently employed?	Y	N	Have you ever served in the military?	Y	N
Are you covered under an employer or union policy?	Y	N	Have you made changes to your choice of Medicare options in the last open enrollment period?	Y	N
Do you have a secondary insurance policy?	Y	N	Are you a new patient to this practice and are you in a preexisting provision with your insurance carrier?	Y	N

If have received services by another provider for the condition for which I seek treatment today, I will promptly disclose any necessary information to my insurance carrier necessary to resolve any issues they may have. I understand and I agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. It is my responsibility to notify you of any changes in my status or the above information.

_____ _____

Patient Signature Date