



A Rogue Valley Physicians, PC clinic

Please fill in the following information completely (Please Print)

PATIENT INFORMATION:

TODAY'S DATE \_\_\_\_\_

NAME \_\_\_\_\_ HOME PHONE: \_\_\_\_\_
LAST FIRST MIDDLE

IF MINOR CHILD, PARENT(S) NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_
STREET, PO BOX CITY STATE ZIP

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY # \_\_\_\_-\_\_\_\_-\_\_\_\_ MARITAL STATUS \_\_\_\_ SEX \_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

HAVE YOU EVER RECEIVED MEDICAL TREATMENT UNDER ANOTHER NAME: [ ] YES [ ] NO

IF YES, UNDER WHAT NAME? \_\_\_\_\_

RESPONSIBLE PARTY: If same as Patient, check box [ ]

NAME \_\_\_\_\_ HOME PHONE: \_\_\_\_\_
LAST FIRST MIDDLE

RELATIONSHIP TO ABOVE PERSON: [ ] SPOUSE [ ] PARENT [ ] CUSTODIAL PARENT [ ] RELATIVE (please check one)

ADDRESS \_\_\_\_\_
STREET, PO BOX CITY STATE ZIP

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY # \_\_\_\_-\_\_\_\_-\_\_\_\_ MARITAL STATUS \_\_\_\_ SEX \_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

SPOUSE INFORMATION: If same as Responsible Party, check box [ ]

NAME \_\_\_\_\_ HOME PHONE: \_\_\_\_\_
LAST FIRST MIDDLE

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY # \_\_\_\_-\_\_\_\_-\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

INSURANCE INFORMATION (please check those which apply)

PLEASE PRESENT CURRENT INSURANCE IDENTIFICATION CARD(S) TO RECEPTIONIST. PROOF OF INSURANCE IS REQUIRED.

I HAVE: [ ] MEDICARE [ ] MEDICAID [ ] HEALTH INSURANCE [ ] NO INSURANCE

MEDICARE ID# \_\_\_\_\_ MEDICAID CARD ID#: \_\_\_\_\_

(if Medicare, complete back of form)

PRIMARY COVERAGE:

HEALTH INSURANCE: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

POLICY HOLDER'S NAME \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX \_\_\_\_

EMPLOYER \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

SECONDARY COVERAGE:

HEALTH INSURANCE: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

POLICY HOLDER'S NAME \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX \_\_\_\_

EMPLOYER \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

MEDICAL TREATMENT RESULTING FROM AN ACCIDENT (Please Complete Accident Report)

I AM RECEIVING MEDICAL TREATMENT AS A RESULT OF AN ACCIDENT: [ ] YES [ ] NO

IF YES, WHAT TYPE OF ACCIDENT? [ ] MOTOR VEHICLE [ ] WORK ACCIDENT [ ] OTHER \_\_\_\_\_

INFORMATION FOR PHYSICIAN:

EMERGENCY CONTACT: \_\_\_\_\_ PHONE \_\_\_\_\_

PERSON OR DOCTOR WHO REFERRED YOU TO THIS CLINIC: \_\_\_\_\_

IF SELF-REFERRED, HOW DID YOU CHOOSE US: [ ] WEBSITE [ ] PHONE DIRECTORY [ ] OTHER \_\_\_\_\_

**MEDICARE SECONDARY PAYOR FORM**

1. Is the patient eligible for Medicare Benefits?..... \_\_\_\_\_  
     Part A (Hospital) benefits..... \_\_\_\_\_  
     Part B (Medical) hospital..... \_\_\_\_\_
2. Is the patient employed?..... \_\_\_\_\_  
     If yes, approximately how many employees?..... \_\_\_\_\_  
     If no, date of retirement..... \_\_\_\_\_
3. Is the patient's spouse employed? ..... \_\_\_\_\_  
     If yes, approximately how many employees?..... \_\_\_\_\_  
     If no, date of retirement..... \_\_\_\_\_
4. Is the patient or spouse covered by:  
     Group Health Insurance?..... \_\_\_\_\_  
     Medicare HMO?..... \_\_\_\_\_
5. Does the patient have a VA service connected disability?..... \_\_\_\_\_
6. Is the patient eligible for Black Lung Benefits?..... \_\_\_\_\_
7. Has the patient had dialysis and been on Medicare more than 18 months?.... \_\_\_\_\_

**SIGNATURE OF PATIENT:** \_\_\_\_\_

**How to code:**

Code group health insurance primary if patient is over age 65 and either patient or spouse is employed, there are 20 or more employees, and the patient is covered by the group health plan.

Code health insurance primary if the patient is under age 65 and either patient or spouse are employed, there are 100 or more employees, and the patient is covered by the group health plan.

Code VA primary only if the patient is receiving treatment related to his/her VA service connected disability.

Any patient being treated as the result of a motor vehicle accident, industrial accident, or injury resulting from a third party liability must have that insurance coded as primary over Medicare.