

Patient Information Sheet (Please Print)

Patient Information

Name: Last First MI SSN: - -
DOB: / / Sex (circle one): Male Female Marital Status (circle one): S M W D SEP

Primary Insurance Information

Name: Phone #: ( ) -
Address: City State Zip
Policy, ID, or Certificate #: Effective Date: / /
Group #:
Name of Policy Holder: DOB: / /
Address (if different than patient): City State Zip

If You Have a Second Insurance; Fill in Below

Insurance Name: Phone #: ( ) -
Address: City State Zip
Policy, ID, or Certificate #: Effective Date: / /
Group #:
Name of Policy Holder: DOB: / /
Address (if different than patient): City State Zip

ABOUT YOUR VISIT WITH MINNESOTA EPILEPSY GROUP For all Patients \* Please Answer both questions

1) Are your services here at Minnesota Epilepsy related to a work related injury? Yes No
If yes, list the name and address of your work compensation insurance company:
Name: Date of Accident: / /
Address: City State Zip
Claim #: Claim Office Phone #: ( ) -
Contact Person:

2) Are your services here at Minnesota Epilepsy related to an automobile injury? Yes No
If yes, list the name and address of your automobile insurance claims office:
Name: Date of Accident: / /
Address: City State Zip
Claim #: Claim Office Phone #: ( ) -
Policy #: Contact Person:

If You Have Medicare; answer the questions below

Is patient covered under the Black Lung Program? Yes No
Is the patient covered under the Dept. of Veterans Affairs? Yes No
Has the Department of Veterans Affairs agreed to pay for this visit? Yes No
Are you currently employed? Yes No
If yes: Does your employer provide health insurance coverage for you or your family members? Yes No
Does the employer have more than 20 employees? Yes No
Is your spouse or parent currently employed? Yes No
If yes: Does his/her employer provide health insurance coverage for him/her or his/her family members? Yes No
Does the employer have more than 20 employees? Yes No
Have you received a kidney transplant? Yes No
If yes, date: / /

Did you sign up for a "Medicare Advantage Plan" also referred to as Medicare Part C? (This includes Medicare HMO, Medicare PPO, Medicare Private fee-for-service Plan (PFFS) or Medicare Special Needs Plan) Yes No

If yes, please provide us with the Insurance Plan information
Name: Phone #: ( ) -
Address: City State Zip
Policy, ID, or Certificate #: Effective Date: / /
Group #: