Penn Medicine

NEW PATIENT REGISTRATION QUESTIONNAIRE

PRACTICE NAME _____

NAME OF PATIENT

LAST FIRST MIDDLE

SOCIAL SECURITY NUMBER

MAIDEN NAME/ALIAS

DATE OF BIRTH SEX: M F

EMERGENCY CONTACT

( ) AREA CODE EMERGENCY CONTACT TELEPHONE

FATHER'S NAME: _____ MOTHER'S NAME: _____

*It is not mandatory to answer this question. However for statistical purposes, your answers would be appreciated.

RACE: Native American: _____ Asian: _____
Black: _____ White: _____
Eastern Indian: _____ Hispanic Latino/Black: _____
Hispanic Latino/White: _____ Pacific Island: _____
Other: _____

ETHNICITY: Hispanic Latino Non Hispanic/Non Latino

PRIMARY LANGUAGE: _____

COMMUNICATION NEEDS: Interpreter Device Interpreter Needed None

MARITAL STATUS: Married _____ Single _____ Divorced _____
Widowed _____ Separated _____ Other _____

SUBSCRIBER INFO (THE PERSON IN YOUR FAMILY WHO PAYS THE INSURANCE)

LAST FIRST MIDDLE

SOCIAL SECURITY NUMBER

DATE OF BIRTH SEX: M F

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

RELATIONSHIP TO PATIENT

( ) AREA CODE TELEPHONE

EMPLOYER NAME

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

( ) AREA CODE TELEPHONE

PATIENT ADDRESS

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

( ) AREA CODE HOME TELEPHONE

( ) AREA CODE CELL PHONE #

EMAIL ADDRESS

PATIENT EMPLOYMENT INFORMATION

EMPLOYER NAME

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

( ) AREA CODE TELEPHONE

OCCUPATION

PRIMARY CARE/FAMILY PHYSICIAN

MD DO

NAME

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

( ) AREA CODE TELEPHONE

REFERRING PHYSICIAN

MD DO

NAME

FIRST LINE OF ADDRESS

SECOND LINE OF ADDRESS

CITY STATE ZIP

( ) AREA CODE TELEPHONE

COMMENTS:

If you are currently covered under Medicare, please complete questionnaire on the back of this form.

A copy of Front and Back of insurance card is <u>required</u>

"Medicare Secondary Payer Questionnaire"

Patient Name: _____

Medicare Beneficiary Number _____

Effective Date: _____ Expiration Date:_____

1) Are you receiving Black Lung Benefits? Yes or No (Please circle one)

If yes, Date Benefits Began:_____

2) Are the services to be paid by Government Program? Yes or No (Please circle one)

3) Are the services to be paid by Veterans Affairs? Yes or No (Please circle one)

4) Are the services to be paid by Research Grants? Yes or No (Please circle one)

5) Was the illness/injury due to an accident? Yes or No (Please circle one)

If yes, Work related injury/illness? Date:_____
Automobile Accident? Date:_____
Other type of accident? _____ Date:_____

6) Are you entitled to Medicare based on Age? Yes or No (Please circle one)

If yes, are you or your spouse currently employed? Yes or No (Please circle one)
If no, please provide retirement date:
Patient:_____ Spouse:_____
Does the patient's employer employ 20 or more employees? Yes or No (Please circle one)
Give approximate number of employees:_____
Does the spouse's employer employ 20 or more employees? Yes or No (Please circle one)
Give approximate number of employees:_____

7) Are you entitled to Medicare based on Disability? Yes or No (Please circle one)

If yes, is the patient the dependent of an employed family member? Yes or No (Please circle one)
Are you or your spouse currently employed? Yes or No (Please circle one)
If no, please provide retirement date:_____
Does the employer employ 100 or more employees? Yes or No (Please circle one)
Give approximate number of employees:_____
Does the employer provide a Group Health Plan? Yes or No (Please circle one)
If yes, please provide copy of Insurance card.)

8) Are you entitled to Medicare based on End Stage Renal Disease? Yes or No (Please circle one)

If yes, did you receive a kidney transplant? Yes or No (Please circle one)
Date of transplant:_____
Date of first dialysis treatment:_____

Did you participate in a self dialysis-training program? Yes or No (Please circle one)
Date training began:_____
Is the patient within 30-month coordination period? Yes or No (Office Use Only)

Signature: _____ Date:_____