Patient Information Screening Form

Norwich Medical Associates
12 Case Street, Suite 103
Norwich, Connecticut 06360
860-889-0147

Date: ____

Name:
____

Home Phone: ___________________ Work Phone: ___________________Cell:____________________

Email Address: ____

Home Address: _________________________________ City: _________________ Zip: ______________

Spouse's Name: _________________________________ Work Phone: ___________________________

Social Security #: ________________________________ Date Of Birth: ___________________________

Whom may we contact in case of emergency: ____?

1) Did you sustain an injury at work?

Y N

2) Are your injuries accident related?
Y N

3) Is your spouse or family member employed?
Y N

4) Are you currently employed?
Y N

5) Do you have a secondary or supplement policy?
Y N

6) Have you ever served in the military?
Y N

7) Are you covered by any other health plan?
Y N

8) Are you enrolled in Medicare Advantage?
Y N

Have you made any changes to your Medicare or Medicare Advantage Plan in the last open enrollment period? This period is from October – December each year.
Y N

If you have answered yes to any of the questions please complete page 2.

I certify that this information is true and correct to the best of my knowledge. I understand it is my responsibility to update Norwich Medical Associates of any changes in my insurance. I further understand that I will asked to update this information on an annual basis.

___________________________________ ____

Signature of policyholder

Patient, Guardian or Legal Representative

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Name: ____

Date: ____

If you sustained an injury at work please provide your proof of claim from your employer or WC Company and a brief explanation of your injury.

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____
____

If your injuries are accident related please provide your adjusters name and associated claim number and a brief explanation of your injury.

____
____
____

Please provide spouse's or family member's place of employment.

____

Please provide your place of employment.

____

Please provide a copy of your secondary or supplement card.

*Please provide a copy of your military benefits (insurance card), if applicable.

*Please provide a copy of your Medicare Advantage card, if applicable.

We will copy your card for you! Thank you for taking the time to update your information