David Gilboe and Assoc., Inc

Medicare Patients

1.) Are you presently working? Yes ☐ No ☐
If not, give retirement date: _____

2.) Is your spouse employed? Yes ☐ No ☐
If not, give retirement date: _____

3.) Are you covered by a health insurance plan through your own current employment or that of a family member? (not retiree coverage) Yes ☐ No ☐

If yes, please list the insurance plan and policy numbers:
_____
_____
_____
_____
_____

4.) Are you entitled to benefits under Veterans Administration?
Yes ☐ No ☐

5.) Is this medical condition due to an accident of any kind?
Yes ☐ No ☐

6.) Please check the reason you are eligible for Medicare:
Age 65 or over ☐ Disabled ☐

Authorization to bill Medicare for services and to furnish information concerning treatment. I hereby assign to David Gilboe And Associates Inc. all payments for medical services and I understand that I am responsible for any amount not covered by insurance.

Signature_____ Date_____