EMPCLAIMS
No Claim Left Behind

Uninsured Patient Questionnaire:

Do you currently have health insurance from any source?

Family Coverage: Yes/ No
Employment: Yes/ No
Medicaid: Yes/ No
Medicare: Yes/ No
Others: _____

Did you have health insurance in the past? Yes/ No
Family Coverage- Yes/ No
Employment: Yes/ No
Medicaid: Yes/ No
Medicare: Yes/ No

Others: _____

Employment related insurance termination:

Date of employment termination:_____

Date of insurance Termination: _____
Copy of old insurance available: Yes/ No
Have you applied for COBRA through your employer? Yes/ No

Date Applied: _____

Non- employment related:
If you had prior insurance, when did you lose it: _____

Have you applied for Medicaid? Yes/ No

Application Date: _____

Patient Attestation:
I declare that the information that I have provided is accurate to the best of my knowledge. I do not have any other insurance coverage and if any other coverage is identified then I agree to pay for the full cost of the services provided.

Signature: _____ Date: _____

Uninsured Patient Intake Form

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Last Name _____ First Name: _____ Middle:_____

Date of Birth:_____

Gender: _____

Home Address

Address : _____

City: _____ State: _____ Zip: _____

Mailing Address: If different from above

Address : _____

City: _____ State: _____ Zip: _____

SSN: _____

State of Residence: _____

State ID/ Drivers License No._____

ID Copy Available: Yes/ No