

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\_\_\_\_\_