Patient Name: ______________________________ **Patient ID #:** __________________________

MEDICARE PATIENT HISTORY

If Medicare eligible you must answer all the following questions.

1. Are you enrolled in a Medicare HMO (ex. Medicare Complete/Advantra)? Yes/No
   If yes: Medicare HMO ID# ___________________________ Group # ______________
   If no: Medicare ID# ___________________________________
2. In the last year have you resided in another state? Yes/No
   If yes: what state ________________________________
3. Are you or your spouse currently employed? Yes/No
4. Do you carry insurance through that employer? Yes/No
5. If yes: Name of Insurance __________________________ID# ____________________

Are you a diabetic? Yes/No ____________
Are you insulin dependent? Yes/No ____________
Do you have a history of any of the following symptoms (circle all that apply): amputation, foot ulcerations, pre-ulcerative callus, peripheral neuropathy, foot deformity or poor circulation

Name & phone # of diabetic doctor: ____

Have you ever received similar supplies/equipment? Yes/No ____________
If yes, what item are we replacing ____
If yes, why being replaced ____
If yes, who was it purchased from ____
If yes, date of purchase __________________________
If yes, name of insurance carrier billed ____

If patient answered yes or is unsure to above need to check the 3/5 yr rule and obtain signed ABN waiver.

Patient Signature : __________________________________ **Date:** _________________________