MEDICARE PATIENT REGISTRATION

Name: _____
First Middle Last

Prefer to be called: _____Title: Mr. Mrs. Ms. Miss. Dr.

Address:_____
Street # Street Name Apt#

_____
City State Zip

Home Phone: _____ Cell Phone: _____

May we leave test results or messages on your answering machine or voice mail? Yes No
May we leave test results or messages with another person at your home? Yes No
Please list any restrictions regarding release of medical information: _____

_____**Please initial for consent:**_____

Date of Birth: _____ Social Security Number:_____

Spouse Name:_____ Date of Birth_____

Alternate Address: _____
Street # Street Name Apt#

_____
City State Zip

Alternate Phone Number:_____

If Insurance benefits are through an employer or former employer, please list:

_____

Employer Phone:_____ May we call you at work? Yes No
Please initial for consent:_____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name:_____

Phone:_____

Relationship:_____

Please answer the following questions:

YES NO Have you recently joined a Medicare HMO? If yes, identify:_____

YES NO Do you or your spouse work in a company with has more that 20 employees and have coverage through the insurance at that job?

YES NO Are you covered by an HMO/PPO which makes Medicare secondary?

YES NO Is this illness covered by the Veteran's Administration?

YES NO Is this illness covered by the Federal Black Lung or End Stage Renal Disease Program?

YES NO Is this illness due to an automobile accident?

YES NO Is this illness due to an injury at work?

YES NO Are you receiving Medicaid?

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in the place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Signature as it appears on Medicare Card Date

If you have a supplemental policy we are required to keep a separate signature on file:

I request authorized MEDIGAP or Secondary benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP or Secondary carrier any information needed to determine these benefits or the benefits payable for related services.

_____

Signature Date

Thank you for choosing this office to assist in caring for your skin.