Medicare Patient Registration

Name: _____ ❑ Jr. ❑ Sr.
First Middle Last

Prefer to be called: _____ Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss

Address: _____
Street # Street Name Apt. #

_____
City State Zip

Employer: _____ Address: _____

Home Phone: _____ Date of Birth: _____

Work Phone: _____ Social Security # _____

Answer questions below by placing a check **in the appropriate column:**

Yes	No	
❑	❑	Have you recently joined a Medicare HMO? If yes, identify:
❑	❑	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
❑	❑	Are you covered by an HMO/PPO which makes Medicare secondary?
❑	❑	Is this illness covered by the VA (Veteran's Administration)?
❑	❑	Is this illness covered by the Federal Black Lung or end Stage Renal Disease Program
❑	❑	Is this illness due to an automobile accident?
❑	❑	Is this illness due to an injury at work?
❑	❑	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 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 and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP 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 carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Signature as it appears on Medigap Card Date

Do we have your permission to:

Leave a message with your spouse? ❑ Yes ❑ No
May we call you at work? ❑ Yes ❑ No

Please present your insurance cards to the receptionist. The receptionist will make a copy and return them to you promptly. Thank you for choosing this office to assist in caring for your skin.