Center for Advanced Dermatology

Medicare Registration Form

Patient's Information:

Name (as it appears on card): _____
First *Middle* *Last*

Title: ❑Mr. ❑Mrs. ❑Ms. ❑Miss ❑Other: _____ Date of Birth: _____/_____/_____ Age: _____
Month Day Year

Address: _____
Address/P.O. Box *City* *State* *Zip*

Primary Phone: _____ Work Phone: _____ Alt. Phone: _____
(Automated appointment reminder system calls **primary** number. ❑Check here if you do not want any reminder calls)

Gender: _____ Name you prefer to be called by: _____

Primary Care Physician: _____Who referred you to us? _____

Insurance Information:

Medicare Number (including the letter after to nine digit number): _____

Supplemental Insurance Company (if applicable): _____

Name of Insured (Guarantor): _____ Relationship: _____

Policy Number: _____ Group Number: _____

Guarantor's Date of Birth: _____ Employer: _____

As part of our efforts to adopt an electronic records system, please provide the following information:

Race (please circle one): White, American Indian, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, or Other

Preferred Language: _____

Ethnicity (please circle one): Hispanic or Latino, Not Hispanic or Latino, or Unknown

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Center for Advanced Dermatology

Medicare

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 Centers for Medicare and Medicaid Services, or its intermediaries or carriers, 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.

I also understand that I will be responsible for any monies (deductibles, co-pays, etc.) due that are not paid by my insurance.

_____ _____/_____/_____

Signature as it appears on Medicare Card *Month Day Year*

Please Sign So Your Supplemental Authorization is On File:

If you have a supplemental policy and it is a supplemental policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

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

_____ _____/_____/_____

Signature as it appears on Supplemental Card *Month Day Year*

Please present your insurance card(s) and your photo identification to the receptionist. The receptionist will make a copy and return them to you promptly. Thanks for your cooperation.