

# CENTER FOR ADVANCED DERMATOLOGY

## Medicare Registration Form

New Patient    Update    Name Change    Address Change

### Patient's Information:

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

Title:  Mr.  Mrs.  Ms.  Miss      Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_      Age: \_\_\_\_  
 Other: \_\_\_\_\_      *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: \_\_\_\_\_

**Do you give our office permission to discuss your medical information with family members?**

Yes  No    If yes, please provide their name and phone number.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**May we leave personal medical information on your answering machine?**     Yes  No

### Emergency Contact Information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

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## 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.**