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MEDICAL CENTER DERMATOLOGY

Medicare Patient Registration

Name: _____ ☐ Jr. ☐ Sr.
FIRST MIDDLE LAST

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

Address: _____
STREET # STREET NAME APT (UNIT)

City: _____ State: _____ Zip Code: _____

PREFERRED

Home Phone: _____ ☐ Date of Birth: _____
Work Phone: _____ ☐ Social Security #: _____
Cell Phone: _____ ☐ Email: _____

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 benefit 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 to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

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

_____ _____
SIGNATURE DATE

Do we have your permission to:

Leave a message on your answering machine? ☐ YES ☐ NO

May we call you at work? ☐ YES ☐ NO

Please present your insurance cards and your photo identification to the receptionist. The receptionist will make a copy and return them to you promptly.