

# MEDICARE PATIENT REGISTRATION

Name(as appears on Medicare card) \_\_\_\_\_  
Last First Middle Initial

Permanent Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Alternate/Cell Phone \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex: \_\_\_M\_\_\_F Social Security # \_\_\_\_\_

Email Address: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

## Please check an Ethnicity:

Hispanic or Latino    Not Hispanic or Not Latino    Unknown or Not Reported

## Please check a Race:

White    Black or African American    Asian    American Indian or Alaska Native

Native Hawaiian or Other Pacific Islander    More than one Race    Other Race

Unknown or Not Reported

If referred by physician, name of referring Doctor \_\_\_\_\_

Would you like a follow-up letter sent to your Doctor? Yes/No (Please circle one)

In case of emergency who should be notified? \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_ Relationship \_\_\_\_\_

Are there other members of your household that are patients with Southern II Dermatology? Y or N

## Please answer the following questions:

Yes    No

    Are you presently employed?  
If yes, employer name and address \_\_\_\_\_  
\_\_\_\_\_

    Have you recently joined a Medicare HMO?  
If yes, identify the HMO \_\_\_\_\_

    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 another insurance, which makes Medicare secondary?

    Is this illness covered by the Veteran's Administration(VA)?

