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 Il 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)?

Yes	No	
☐	☐	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?

If any of the above answers are yes, Medicare may not be your primary insurance. Please notify our staff.

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 statements:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services 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 be made to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Signature as it appears on Medicare Card Date

SECONDARY/SUPPLEMENTAL INSURANCE

Policy # _____Group # _____

Insured's Name _____Relationship to Patient _____

Insured's Social Security # or ID# _____ Insured's DOB_____

Insurance Company Name _____

Insurance Company Address _____

If you have a secondary/supplemental policy, we are required to keep a separate signature on file.

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

_____ _____

Signature Date