Trident Dermatology
MEDICARE PATIENT REGISTRATION

Name: _____
(First) (Middle) (Last)

Male _____ Female _____ DOB: _____ Age: _____

Address: _____
(Street#) (Street Name) (Apt. #)

_____
(City) (State) (Zip Code)

Employer: _____
(Name) (Address)

Primary Phone: _____ Other Phone: _____

Social Security #: _____

Marital Status: _____ Spouse's DOB if insurance is through them: _____

Please answer yes or no to the following questions:

Yes	**No**	
□	□	Have you recently joined a Medicare HMO or a Medicare Advantage? (If yes, identify:_____)
□	□	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 a HMO/PPO which makes Medicare secondary?
□	□	Is this illness covered by the VA (Veteran's Administration)?
□	□	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:

Referring physician: _____ Phone No:_____

Address:_____

Family Physician (if different): _____

Name of Pharmacy and Phone No:_____

(continued on back)

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 payer 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 benefits 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 and it is a secondary policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file.

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

_____

Signature as it appears on secondary insurance card **Date**

Do we have permission to:

Leave a message on your answering machine: _____ Yes _____No

Whom do you authorize to receive protected health information for you (other than yourself)?

_____

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

Thank you for choosing this office to assist in caring for your skin!

Revised: 09-27-2011