

**Medicare Patient Information**

**PLEASE PRINT CLEARLY**

Office use only

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

Provider: RJA DCD BJB RJL JEM DDS KJG KAS

Patient Name: \_\_\_\_\_  
Last First Initial

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex \_\_\_ F \_\_\_ M Social Security #: \_\_\_\_\_

Mailing Address (all correspondence will be sent to this address):

\_\_\_\_\_  
Street Apt. #  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_  
City State Zip Code

E-Mail Address: \_\_\_\_\_ Cell or Alternate Phone #: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Relationship to Cardholder (circle one) Self Spouse Dependent

Primary Insurance Cardholder: Name: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Supplemental Insurance: \_\_\_\_\_ Relationship to Cardholder (circle one) Self Spouse Dependent

Supplemental Insurance Cardholder: Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

**Do you give our office permission to discuss your medical information with your family or friends?:**  
\_\_\_ YES \_\_\_ NO If yes, please provide their names and phone numbers below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

**I have received a copy of the HIPAA Notice of Privacy Practices ----- Initials ►** \_\_\_\_\_

**Do we have permission to?** Leave a message on your answering machine at home? \_\_\_ Yes \_\_\_ No  
Mail or e-mail special offers to you? \_\_\_ Yes \_\_\_ No

Emergency Contact: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

**Please Sign So We May Have Your Medicare Authorization On File:**

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.

Date: \_\_\_/\_\_\_/\_\_\_ Signature: \_\_\_\_\_

**Payment Policy**

**Medicare:** We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-payment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

**Please present Medicare and Secondary Insurance Card(s) and Photo ID to the receptionist so copies may be made.**