

# Medicare Patient Information

**PLEASE PRINT CLEARLY**

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

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

**Address:** \_\_\_\_\_  
Street Apt. #  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ **E-Mail:** \_\_\_\_\_  
City State Zip Code

**Home Phone:**( ) \_\_\_\_\_ **Work:**( ) \_\_\_\_\_ **Cell:**( ) \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ **Phone #** \_\_\_\_\_

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

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

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

**Secondary Insurance Cardholder:** Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**How did you hear about us:** Radio \_\_ Advance \_\_ GRPress \_\_ InternetWebsite \_\_ Family/Friend \_\_ Other \_\_

**Do you give our office permission to discuss your medical information with family members?**

\_\_ 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.** \_\_ yes \_\_ no

**Do we have permission to?** Leave a message on your answering machine at home? \_\_ yes \_\_ no  
Mail marketing information to you? \_\_ yes \_\_ no

**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.**

**Office Use Only**

Dermatology Associates provider: RJA DCD BJJ RJL JEM KJG KAS