

## Medicare Patient Registration

▶ Please fill out completely and bring with you to your appointment. ◀

Name: \_\_\_\_\_ Title:  Mr.  Mrs.  Ms.  Dr.  
First Middle Last

Mailing / Billing Address: \_\_\_\_\_  
Street # Street Name Apt#  
 \_\_\_\_\_  
City State Zip Code

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

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

In the event of an emergency, who should be notified? Name \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about Cary Skin Center? \_\_\_\_\_

If married, Spouse's \*\*Name: \_\_\_\_\_ Spouses \*\*Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (\*\*This information is **required** if your insurance policy is in your spouse's name)

**Answer questions below by placing a check in the appropriate column:**

- Have you recently joined a Medicare HMO?  Yes  No  
 If yes, identify: \_\_\_\_\_
- Do you or your spouse work in a company which has more than 20 employees and have coverage through insurance at that job?  Yes  No
- Are you covered by a HMO/PPO which makes Medicare secondary?  Yes  No  
 If yes, identify: \_\_\_\_\_
- Is this illness covered by the VA (Veterans Administration)?  Yes  No
- Are you receiving Medicaid?  Yes  No
- Are you a resident of a Skilled Nursing Facility?  Yes  No or Hospice?  Yes  No

**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 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 another policy, we are required to keep a separate signature on file.** Your signature below indicates authorized benefits are made, on your behalf, by the supplemental carrier named below:

Name of other carrier: \_\_\_\_\_  Primary  Secondary

Name of policy holder: \_\_\_\_\_

Social Security # of policy holder: \_\_\_\_\_

I authorize any holder of medical information to release to the above carrier any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
**Signature as it appears on insurance card** **Date**

▶ Please present your insurance cards at time of check-in so copies can be made. ◀