

MEDICARE Patient Registration

Name: _____
Exactly as it appears on your Medicare Card

Address: _____ MALE FEMALE
please circle

City/State/Zip: _____ S M D W
single married divorced widowed

Social Security #: _____ Date of Birth: _____ Age: _____ years

Home Phone #: _____ Cell Phone #: _____

Employer: _____ Address: _____

1) INSURANCE COMPANY _____ ID# _____ ADDRESS _____
2) INSURANCE COMPANY _____ ID# _____ ADDRESS _____

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

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Were you referred here by another physician? If yes, please give the name of the Doctor: _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you recently joined a Medicare HMO ?
<input type="checkbox"/>	<input type="checkbox"/>	Do you or your spouse work in a company that has coverage through the insurance at that job?
<input type="checkbox"/>	<input type="checkbox"/>	Is this illness covered by the VA?
<input type="checkbox"/>	<input type="checkbox"/>	Are you on Medicaid? (our office is NOT a provider with Medicaid - you will be responsible for the balance)
<input type="checkbox"/>	<input type="checkbox"/>	May we leave personal medical information on your answering machine?
<input type="checkbox"/>	<input type="checkbox"/>	May we discuss your medical information with family members? If yes, please provide their name and phone number: _____ _____

This office is required to keep your signature on file authorizing us to file claims to Medicare and your supplemental insurance carrier for you and to release information to that payor if they request it for 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.

In addition, the Health Care Insurance Portability and Accountability Act (HIPAA) requires this practice to publish a Notice of Privacy Practices which describes how your health information may be used and disclosed for the normal healthcare operations of this practice (including the release of information for billing and collection purposes related to your treatment).

Signature as it appears on Medicare Card

Date

PLEASE PRESENT OFFICE STAFF WITH YOUR INSURANCE CARDS