Blue Ridge Dermatology Associates, P.A.

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Medicare Patient Registration

PLEASE PRINT

Today's Date:______________________________ **Name you like to be called:**____

Mr. Mrs. Ms. Dr.

First	Middle	Last	Suffix

Street	Marital Status: M S D W	Sex: M F
City **State** **Zip**	**Date of Birth:** **Age:**	
	Social Security #	

Home Phone #	Work Phone #	Ext.
Cell Phone #	**Email Address:**	

Name of Primary Care Physician:	Phone:
Name of Previous Dermatologist:	**Phone:**

Referral Source: (Please Circle One)
Friend/Relative (Name) **Yellow Pages** **Insurance Plan** **Internet** **Other**

Name & Location of Pharmacy:	Phone:

Primary Insurance Plan Name:	Name of Employer Issuing Insurance:
Policy Holders Name:	**Patient Relationship to Policy Holder:**
Policy Holders Social Security:	**Policy Holders Date of Birth:**

Secondary Insurance Plan Name:	Name of Employer Issuing Insurance:
Policy Holders Name:	**Patient Relationship to Policy Holder:**
Policy Holders Social Security:	**Policy Holders Date of Birth:**

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 assignments of benefits apply.

(TO FILE YOUR MEDICARE or MEDICARE REPLACEMENT PLAN, YOUR SIGNATURE IS REQUIRED)

Signature of patient (legal guardian or power of attorney)	**Date**

You herein authorize payment of medical benefits by your insurance carrier to the physician when an assigned claim is filed. This authorization shall be valid until rescinded in writing or replaced by one at a later date.

(TO FILE YOUR SUPPLEMENTAL INSURANCE, YOUR SIGNATURE IS REQUIRED)

Signature of patient (legal guardian or power of attorney)	**Date**

May we: **Discuss your medical condition with any member of the family or designated representative? NO YES**

If yes, whom:____ **Relationship:**______________________________

Phone number if different from yours:____

Signature: **Date:**

PLEASE READ & SIGN THE FINANCIAL AGREEMENT ON THE BACK OF THIS FORM