Blue Ridge Dermatology Associates, P.A.

4225 Macon Pond Rd., Ste 300 Raleigh, NC 27607 1110 S.E. Cary Parkway, Ste 100 Cary, NC 27518 919-781-1050

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:**		

Race (Please circle one): White Black/African American Asian American Indian or Native Alaskan Native Hawaiian/Pacific Islander

Ethnicity (Please circle one): Hispanic/Latino Non-Hispanic/Latino

Preferred Language (Please circle one): English Spanish Other: _____

Name of Previous Dermatologist:	**Phone:**

Primary Insurance Plan Name:	**Name of Employer Issuing Insurance:**
Policy Holders Name:	**Patient Relationship to Policy Holder:**
Secondary Insurance Plan Name:	**Name of Employer Issuing Insurance:**
Policy Holders Name:	**Patient Relationship to Policy Holder:**

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 carriers 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 This authorization shall be valid until rescinded in writing or replaced by one later.

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

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