

Dermatology and Laser Institute of Colorado, P.C.
9695 S Yosemite St, Ste 120
Lone Tree CO 80124

MEDICARE PATIENT REGISTRATION

Name: _____ Jr. Sr.
Last Middle First

Prefer to be called: _____ Title: Mr. Mrs. Ms. Miss

Address: _____
Street # Street Name Apt #

City State Zip

Employer: _____ Address: _____

Home Phone: _____ Date of Birth: _____

Work Phone: _____ *Month / Day / Year*

Social Security #: _____

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

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you recently joined a Medicare HMO?
If yes; identify: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you covered by a HMO/PPO which makes Medicare secondary? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is this illness covered by the VA (Veteran's Administration)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is this illness covered by the Black Lung or End Stage Renal Disease Program? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is this illness due to an automobile accident? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is this illness due to an injury at work? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you receiving Medicaid? |

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 to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card Date

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on Medigap Card Date

Do we have your permission to:

Leave a message on your answering machine? Yes No

May we call you at work? Yes No

Please present your insurance cards and your photo identification to the receptionist. The receptionist will make a copy and return them to you promptly.

Thank you for choosing this office to assist in caring for your skin.