MEDICARE Patient Registration

Name: _____ single married divorced widowed

Exactly as it appears on your Medicare Card

please circle

MALE FEMALE

Address: _____

City/State/Zip: _____

Pharmacy:_____

Phone #_____

FOR PRACTICE UPDATES AND INFORMATION

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

Home Phone #: _____ Cell Phone #: _____

Employer: _____ Address: _____

1) INSURANCE COMPANY _____ ID# _____ ADDRESS_____

2) INSURANCE COMPANY _____ ID# _____ ADDRESS_____

3) Prescription Drug Coverage Carrier: _____ID#_____

……ELECTRONIC MEDICAL CHART……

Email: _____ (**THIS IS IMPORTANT FOR YOUR PATIEINT PORTAL ACCESS**)

Do you want access to your Electronic Chart through our patient portal? Yes_____ No_____

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

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