Name:
DOB:
Chart:
Age:
Date:

Medicare Patient Registration

PATIENT DATA

Name (Last, First, MI): _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ SSN: _____ Sex: _____

☐ Single ☐ Married ☐ Divorced ☐ Widow

Primary Care Physician: _____ Name of Previous Dermatologist: _____

Race: ☐ Caucasian ☐ America Indian ☐ Asian ☐ African American ☐ Native Hawaiian ☐ Type-Unknown
☐ I prefer not to answer this question

Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Type Unknown ☐ I prefer not to answer this question

Preferred Language: ☐ English ☐ Spanish ☐ Hindi ☐ Chinese ☐ Korean ☐ Italian ☐ Japanese
☐ Vietnamese ☐ I prefer not to answer this question

Smoking Status: ☐ Current every day smoker Packs per day: _____
☐ Current some day smoker Packs per day: _____
☐ Smoker, current status unknown ☐ Never smoker ☐ Former smoker ☐ Unknown if ever smoked

If you have ever smoked: Year started: _____ Year stopped: _____

Please provide your email address so we may send you a link to access your patient portal. By providing your email address you are giving Pinehurst Dermatology permission to send you an invitation to view your Pinehurst Dermatology related personal health information. This is not used for any other purpose and is not given to any third party.

Email: _____
Do you consent to receive medical results by email? ☐ Yes ☐ No

Answer Questions Below By Placing a Check In The Appropriate Column:

YES	NO	
☐	☐	Have you recently joined a Medicare HMO? If yes, identify: _____
☐	☐	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
☐	☐	Are you Covered by a HMO/PPO which makes Medicare secondary?
☐	☐	Is this illness covered by the VA (Veterans Administration)?
☐	☐	Is this illness Covered by the Federal Black Lung or End Stage Renal Disease Program?
☐	☐	Is this illness due to an automobile accident?
☐	☐	Is this illness due to a injury a Work?
☐	☐	Are you receiving Medicaid?
☐	☐	Are you currently in a hospital, skilled nursing, or rehabilitation facility?
☐	☐	Have you been discharged from a hospital, skilled nursing, or rehab facility in the last 30 days?

REFERRAL DATA

☐ Referring Physician: _____ ☐ Friend/Relative: _____
☐ Insurance Plan Directory: _____ ☐ Yellow Pages: _____
☐ Other (specify): _____

CONSENT

May we leave a message on your answering machine or voicemail? ☐ Yes ☐ No
May we discuss your medical condition with any member of your family? ☐ Yes ☐ No
If yes, whom? _____ Relationship: _____
Signature: _____ Date: _____

This office is required to keep your signature on file authorizing us to file claims to Medicare and any Medigap policy you may have 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/Medigap 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 assignments. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____
Signature as it appears on Medicare Card Date