PONTE VEDRA
Dermatology & Aesthetic Surgery

Medicare Patient Registration

Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss Name: ______________________________ ❑ Jr ❑ Sr
First *Middle* *Last*
❑ Single ❑ Married ❑ Other

Address: ______________________________
Street # *Street Name* *Apt #*

____
City *State* *Zip*

Employer: ______________________ Address: ______________________
(If Applicable)

Home Phone: ______________________ Date of Birth: ______________________
Month / Day / Year

Work Phone: ______________________ Cell Phone: ______________________

Social Security #: ______________________ Referred By: ______________________

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 an 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 any injury at work?
❑	❑	Are you receiving Medicaid?

Is Medicare your primary insurance? ❑ Yes ❑ No If no, please complete the following:

Name of Insurance: ______________________ Insured Name: ______________________

Insured Date of Birth: ______________ ID # ______________ Group # ______________

Employed By: ______________________

- Over -