

MEDICARE PATIENT REGISTRATION FORM

THIS FORM IS FOR ADULT PATIENTS WITH MEDICARE. Patients under 18 or on a parent's insurance should use the MINOR PATIENT form instead. Adult patients who do not have Medicare should use the ADULT PATIENT form instead.

PATIENT AND PHONE INFORMATION

Bold Fields are required; others are optional.

Last Name:		First:		Middle:		Nickname, if different:	
Date of Birth (m/d/yy):		Age (in years):		Sex:		Title:	
				<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Jr <input type="checkbox"/> Dr <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Sr <input type="checkbox"/> II	
Best Phone:		Alternate Phone (if any):		Email Address (if you would like):			
<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work					
May we leave a message at this phone number?		May we leave a message at this phone number?		Would you like appointment reminders by email when this feature is available?			
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No			

MAILING ADDRESS

Please provide the address where bills should be mailed.

Street Address or PO Box:		Apartment Number (if any):	
City:	State:	Zip:	

FAMILY INFORMATION

If you are also covered by an employed spouse's insurance, or if your spouse is an existing patient with us, please provide spouse name and date of birth.

Marital Status:		Spouse Full Name (First, M.I., Last):		Spouse Date of Birth (m/d/yy):	
<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed					

May we discuss your medical condition with your spouse? Yes | No | Other named person: _____

MEDICARE AND OTHER INSURANCE INFORMATION

Please check **only ONE** of these options to explain how we should set up your Medicare and other (if any) insurance.

<input type="checkbox"/> Medicare Part B primary with other insurance secondary.	<input type="checkbox"/> Medicare Advantage Plan (claims not sent to Medicare).
<input type="checkbox"/> Medicare Part B only (you are responsible for paying your \$135 annual deductible and 20% coinsurance).	<input type="checkbox"/> Other insurance primary with Medicare Part B secondary (you are employed, for example).

COORDINATION OF CARE

Referring Physician (name):	Phone (if you have it):
Pharmacy of Choice (name):	Phone (if you have it):

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please sign below to acknowledge that you have received a copy of the Notice of Privacy Practices for Lake Washington Dermatology. (Your signature is only an acknowledgment of receipt, not any form of consent.)

X _____

Adult Patient Signature

_____ **Date**

FOR OFFICE USE ONLY IF PATIENT REFUSES TO SIGN. I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Patient refused to sign Communications barriers Emergency situation Other (explain)

X _____

Office Employee Signature

_____ **Date**

TURN OVER