

# MEDICARE PATIENT REGISTRATION FORM

**THIS FORM IS FOR ADULT PATIENTS WITH MEDICARE.** Patients under 18 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.

<b>Last Name:</b>		<b>First:</b>		<b>Middle:</b>		<b>Prefer to be called:</b>	
<b>Date of Birth</b> (m/d/yy):		Age (in years):		<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		Title: <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	
<b>Best Phone:</b> <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		<b>Alternate Phone</b> (if any): <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Email Address:			
May we leave a message at this phone number? <input type="checkbox"/> Yes <input type="checkbox"/> No		May we leave a message at this phone number? <input type="checkbox"/> Yes <input type="checkbox"/> No		Would you like appointment reminders by email/text? <input type="checkbox"/> Yes <input type="checkbox"/> No			

## MAILING ADDRESS

Please provide the address where bills should be mailed.

<b>Street Address or PO Box:</b>		<b>Apartment Number</b> (if any):	
<b>City:</b>	<b>State:</b>	<b>Zip:</b>	

## 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.

<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	<b>Spouse Full Name</b> (First, M.I., Last):	<b>Spouse Date of Birth</b> (m/d/yy):
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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 annual deductible and 20% coinsurance).	<input type="checkbox"/> Other insurance primary with Medicare Part B secondary (you are employed, for example).

## COORDINATION OF CARE

<b>Referring Physician</b> (name):	<b>Phone</b> (if you have it):
<b>Pharmacy of Choice</b> (name and address):	<b>Phone</b> (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 Advanced Dermatology Northwest (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**

**ONCE COMPLETED, PLEASE EMAIL FORM TO: CONTACTUS@ADVANCEDERMNW.COM**