MEDICARE PATIENT	ON	<b>Today's Date:</b> /			
Name:				Sex	
Name: First	Middle	Last			
Mailing Address:					
		Ci	ty	State	Zip
		h /	Race:		
Email Address	Preferre	d Language		Black, Native H	awaiian, Other
Home Phone:		Work/Cell		rea Code	
Area Code					
Social Security Number _		Ethr	iic Group	: Hispanic or La Not Hispanic of	tino, Unknown or Latino
Marital Status:	Date of B	irth:/	_/ A	ge:	
*Spouse's Name:(*required if Medicare is second	ondary and your spous	*D	ate of Bi	rth:/ e)	*
Emergency Contact:			P	hone:	
Referred by:		Primary Care P	hysician:		
This office is required to ke and to release information to read and sign the following. I authorize any holder of me Administration and Health information needed for this used in place of the original Dermatology PSC, who according to the original dermatology PSC.	o that payer if they statement: edical or other info Care Financing Ac or a related Medic , and request payn	ormation about a dministration or care claim. I per ment of medical	me to releate its intermediate copinsurance	ase to the Social ediaries or carry of this author benefits to Ba	of a claim. Please of a claim.
Signature (required) as it appe	ears on Medicare Ca	 urd		ate	
If you have a supplemental over", sends info to 2 <sup>nd</sup> poli	policy and it is a n	nedigap policy (	Medicare	Carrier autom	atically "crosses
I request authorized benefits holder of medical information determine these benefits or	on to release to the	e above medigaj	o carrier a		-
Signature (required) as it appe	ears on Supplement/	Secondary Card	D	ate	
Referral Information: I am physician, to consultants if a and prescriptions. I also aut	needed and as nec	essary to proces	s insuranc	e claims, insur	ance application
Signature:			Date	/ /	

PLEASE PRESENT INSURANCE CARDS SO COPIES MAY BE MADE