MEDICARE PATIENT REGISTRATION

DOCTOR Feins

Name: _____ ❑ Jr. ❑ Sr.

Prefer to be called: _____ Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss

Date of Birth: _____
Month / Day / Year

Address: _____
Street # Street Name Apt #

_____
City State Zip

Day Phone: (_____)_____ Evening Phone: (_____)_____

Primary Care Physician: _____

Primary Care Physician Address and Phone Number: _____

Who referred you? _____

Robert S. Feins, M.D., P.A., F.A.C.S.
Plastic and
Reconstructive Surgery

Doctors Park
144 Tarrytown Road
Manchester, NH 03103
603-647-4430
Facsimile 603-647-4877

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 though the insurance at that job?
❑	❑	Are you covered by a HMO/PPO which makes Medicare secondary?
❑	❑	Is this illness covered by the VA (Veteran's 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 an injury at work?
❑	❑	Are you receiving Medicaid?

Please present your insurance card(s) and your photo identification to the receptionist. The receptionist will make a copy and return them to you promptly.

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

Insurance Information:

Do you have insurance? ❑ Yes ❑ No

Primary Insurance Carrier:_____

Name of Insured (Guarantor): _____ Guarantor Date of Birth: ____/____/____

Secondary Insurance Carrier: _____

Name of Insured (Guarantor): _____ Guarantor Date of Birth: ____/____/____

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____/_____/_____

Signature as it appears on Medicare Card **Date**

Robert S. Feins, M.D., Prof. Ass'n
Medicare Patient Registration - continued

If you have a supplemental policy and it is a MEDIGAP policy to which you're Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____/_____/_____
Signature as it appears on Medicare Card Date

Do you give our office permission to discuss your medical information with family members?

❑ YES ❑ NO If yes, please provide their name and phone number:

Name: _____ Relationship: _____

Phone # (day): (_____)_____ Evening #: (_____)_____

May we leave personal medical information on your answering machine at home?

❑ YES ❑ NO

May we e-mail personal medical information to you?

❑ YES ❑ NO E-mail address: _____

Patient Signature: _____ Date: _____/_____/_____

Emergency Contact Information:

In case of an EMERGENCY whom should we notify?

Relationship to Patient:

_____ Phone: _____

Preferred Pharmacy information:

Name of Pharmacy: _____

Address: _____

_____
City State Zip

Phone number: _____ Fax number: _____