

CARY L. DUNN, MD, PA

SKIN CANCER SPECIALIST™

New Patient Name Change Address Change Insurance Change

THIS SECTION MUST BE COMPLETED BY ALL PATIENTS:

Name _____
Last First M.I.

Date of Birth: ___/___/___ Age: _____ Sex: Male Female SS# _____-_____-_____

ADDRESS:

Mailing Address _____
Street City State Zip

Northern Address _____

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____ e-mail: _____

Emergency Contact: _____ Phone _____

Name/Relationship

Any Restrictions on contacting you? _____

Do we have permission to discuss your medical condition or test results with any member of your household?

Yes No Comments: _____

How did you hear about us? Radio Television Flyer Skin Cancer Screening

Newspaper / If so which one? Herald Tribune Desoto Sun Peace River Shopper

Other: _____ Physician Referral _____

INSURANCE CARRIER INFORMATION:

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

PRIMARY INSURANCE HOLDER ***MUST HAVE*** (if different from patient)

Name: _____ Home Phone: () _____
Last First M.I.

Address: _____
Street City State Zip

Date of Birth: ___/___/___ Social Security Number _____

PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION AND RELEASE OF INFORMATION ON FILE

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I further authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims.

Date: ___/___/___ Signature: _____

I ACKNOWLEDGE THAT I HAVE READ AND AGREE TO THE Cary L. Dunn MD, PA Office Financial Policy and that I HAVE READ AND CONSENT TO THE Cary L. Dunn MD, PA Notice of Privacy Practice (HIPPA) Policy.

Date: ___/___/___ Signature: _____

Please provide your insurance card(s), co pay and driver's license to the receptionist along with this form.

Life Time Authorization

This office is required to keep your signature on file authorizing us to file claims to Medicare for you to release information to that payor if they require it for proper consideration of a claim.

Please read and sign the following statement.

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

Signature as it appears on Medicare Card

Date: ____/____/____

If you have a secondary, supplemental insurance policy and it is a MEDIGAP policy to which your Medicare carrier automatically "crosses over" we are required to keep a separate signature on file. **(MEDIGAP is an insurance policy that is recognized by Medicare's system. Once your Medicare claim is paid, Medicare will automatically cross over your explanation of benefits from Medicare's payment over to your Medigap insurer so that your co-insurance is automatically paid on your behalf).**

I request authorized MEDIGAP benefits to 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 Medigap Policy

Date: ____/____/____