BRADENTON
Skin Cancer

Patient Information

Patient Name:_____Age:_____Sex:_____

Birthdate:_____Single:____Married:_____Widowed:_____Divorced_____

Social Security No:_____Home Phone No:_____

Address:_____

City:_____State:_____Zip Code:_____

Email:_____Cell No._____

Employed by:_____Phone No:_____

Address:_____City:_____State:_____Zip Code:_____

Spouse's Name:_____Referred by:_____

Person to contact in case of emergency:_____Phone No:_____

Medicare:___Yes___No___Medicaid:___Yes___No___Medical Insurance:___Yes___No_____

Insurance Company:_____Customer Service No:_____

Member No:_____Group No:_____

Claims Address:_____City:_____State_____Zip Code:_____

Does your insurance require a second opinion:_____Yes_____No_____

Lifetime Medicare B Signature Authorization:

For service beginning _____, I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries of carriers, or to other billing agents of Ted F. Kadivar, M.D., P.A. any information needed for this or a related Medicare claim. I permit a copy of this authorization to be in place of the original and request payment of medical insurance benefits, either to myself or to the party who accepts assignment.

Patient's Signature:_____Date Signed:_____

Signed by:_____(If other than beneficiary)
Reason patient unable to sign:_____

Authorization for Release of Information and Assignment of Medical Benefits:

I hereby assign all medical and/or surgical benefits to which I am entitled to Ted F. Kadivar, M.D., P.A. I understand that I am financially responsible for all charges not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient's Signature:_____Date Signed:_____

Ted F. Kadivar, M.D., P.A., 250 2nd St. East, Suite 4C, Bradenton, FL 34208 Phone 941-744-5860 Fax 941-744-5681

(Revised 06/2012)