MINNESOTA CLINIC FOR HEALTH & WELLNESS

PATIENT REGISTRATION FORM

PATIENT

Last Name	First	MI	❑ Male ❑ Female	Marital Status
Address	City		St	Zip
Home Phone	Cell Phone	Work Phone	Language Preference	Race
Social Security	Date of Birth	Email Address		
Employer	Employment Status: (circle one) Full-time Part-time Other:_____		Occupation	
Employer Address	City		St	Zip
Name of Referring Physician			Primary Care Physician	
Emergency Contact **NAME, PHONE, RELATIONSHIP**				
Is this a Worker's Compensation Claim? Yes ❑ No ❑	Date of Injury		Claim No.	

RESPONSIBLE PARTY

Last Name	First	MI	❑ Male ❑ Female	Marital Status
Address (if different)	City		St	Zip
Home Phone	Cell Phone	Work Phone	Relationship to Patient: ❑ Parent ❑ Spouse ❑ Other:_____	
Social Security	Date of Birth			
Employer	Employment Status: (circle one) Full-time Part-time Other:_____		Occupation	
Employer Address	City		St	Zip

PRIMARY INSURANCE

Primary Insurance Company	Relationship to Patient		Occupation
Insurance Policy Holder's Name (if different)	Insurance ID Number		Insurance Group Number
Social Security Number	Birth Date	Primary Phone	Work Phone
Employer	Employer Phone		Employment Status (circle one): Full-time Part-time Other:_____
Employer Address	City	State	Zip

I certify that in applying for benefits under Title XVIII and/or XIX of the Social Security Act, the above information is correct to the best of my knowledge. I also acknowledge that I am financially responsible for all charges whether or not covered by insurance including deductibles and co-insurance.
Signature X_____ _____Date_____

Assignment of Benefits (permission for insurance co. to send payment to us)-valid until revoked:
I hereby assign, transfer and set over to Medical Care Services, PA all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with _____ Insurance company(s).
Signature X _____ Date _____

Permission to give information:
I hereby give permission to Medical Care Services, PA to leave information on my answering machine and to give information on my health status to the following person(s):

_____
Signature: X _____ Date_____

Notice of Privacy Practices
My signature below means that I have received a copy of the Minnesota Clinic for Health and Wellness' Notice of Privacy Practices, which explains in more detail my rights to, and some of the uses and disclosures of my health information.

Signature: _____ Date: _____