MINNESOTA ALLERGY & ASTHMA, LLC

Patient Registration

Date ________________________

PATIENT NAME ____ DOB ____________
Last First MI

Address ____
Street Apt# City State Zip Code

Social Sec.# ________________ Male___ Female___ Home Phone (_______) ____________ S M W D
Marital Status (Please Circle)

Patient's Employer ________________ Occupation ________________ Work Phone (_______) ____________

Responsible Party: Self____ Other: ______________________________
Name Address

Family Physician and/or Clinic ______________________________
Name Address

Who referred you to our clinic? Friend___ Family Member___ Other: Name ________________ Physician___

Name/Address of Referring Physician ______________________________
Name Address Phone #

INSURANCE POLICYHOLDER'S INFORMATION (if different from patient)

Name ________________ Soc Sec# ________________ DOB ________ Relationship to Patient ________

Address ____
Street Apt# City State Zip Code

Home Phone # ________________ Work Phone # ________________ Employer Name ________________

Employer Address ____

PRIMARY Insurance ________________

Group # ________________

ID # ________________

Policyholder Name/DOB ________________

SECONDARY Insurance ________________

Group # ________________

ID # ________________

Policyholder Name/DOB ________________

EMERGENCY CONTACT PERSON

______________________________ (_____) ____________ (_____) ____________
Name Home Phone# Work Phone#

In order to comply with state requirements, we ask that you tell us your country of origin, racial/ethnic background and preferred language. Your answers will be confidential and will have no effect on the care you receive.

In what country were you born ________________ Race/Ethnicity ________________ Language ________________

TO RESPECT YOUR PRIVACY, HOW MAY WE REACH YOU REGARDING YOUR HEALTH INFORMATION, TEST RESULTS, MEDICATION, BILLING, APPOINTMENTS?

Choose ALL that apply:

- ☐ 1) Leave a message on voice mail: Home__ Work__ Cell# (____) ____________ E-mail ________________
- ☐ 2) Okay to leave message with: ______________________________
Name
- ☐ 3) Do not leave message on voice mail.

Signature ______________________________ Date ____________

I hereby request and authorize direct payments to Minnesota Allergy & Asthma, LLC. I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for my balance regardless of insurance. I also understand that if I have no insurance, I will be required to pay the cost of the services at the time I am seen. I understand that finance charges will accrue on any balance over 30 days. This form also authorizes the release of any medical information necessary to process this claim and to my referring physician and other providers involved in my care.

Date: ________________ Signed: ______________________________

Medical Authorization: I request that payment of authorized Medicare benefits be made to me or on my behalf to Minnesota Allergy & Asthma, LLP, for any services provided to me by that clinic. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Date: ________________ Signed: ______________________________