

PLEASE COMPLETE, PRINT OUT FORM AND BRING WITH YOU TO YOUR APPOINTMENT

Crown Medical Center – Minneapolis, MN

REGISTRATION FORM

Today's date:		PCP:				
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss	Marital status (circle one)	
				<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	<input type="checkbox"/> Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:		Social Security no.:		Home phone no.:	Cell phone no.:	
		- -		() -	() -	
P.O. box:		City:		State:	ZIP Code:	
Occupation:		Employer:		Employer phone no.:		
				() -		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
Other family members seen here:						

INSURANCE INFORMATION								
(Please give your insurance card to the receptionist.)								
Person responsible for bill:		Birth date: / /		Address (if different):		Home phone no.:		
						() -		
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Occupation:		Employer:		Employer address:		Employer phone no.:		
						() -		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Please indicate primary insurance		<input type="checkbox"/> (Insurance Company Name)						
<input type="checkbox"/> Welfare (Please provide coupon / card)				<input type="checkbox"/> Other				
Subscriber's name:		Subscriber's S.S. no.:		Birth date: / /		Group no.:	Policy no.:	Co-payment:
								\$.00
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			
Name of secondary insurance (if applicable):		Subscriber's name:			Group no.:		Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			

IN CASE OF EMERGENCY							
Name of local friend or relative (not living at same address):		Relationship to patient:		Home phone no.:		Work phone no.:	
				() -		() -	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.							
_____ Patient/Guardian signature				_____ Date			