# THE ENDOCRINOLOGY CLINIC OF MINNEAPOLIS. P.A.
## PATIENT REGISTRATION page 1

www.endoclinic.net

Date: ______________ **Please use Black Ink** Account #: ________________________

## Patient Information

Patient Name | First | Middle Initial | Last | Name you prefer to be called

| Birth Date | Age | Sex M F | Social Security # | Email address |
|---|---|---|---|---|

Home Address | Street | Apt. # | City | State | Zip Code

| Home Phone ( ) | Work Phone ( ) Ext. | Pager/Cell Phone |
|---|---|---|

| Marital Status M W D S | Employment Status FT PT None Self Retired Military Student | Occupation |
|---|---|---|

| Employer | How Long There? |
|---|---|

| Spouse Name | Spouse Social Security # | Spouse Date of Birth | Spouse Employment Status FT PT None Self Ret Military |
|---|---|---|---|

| Spouse Occupation | Spouse Employer | Spouse Work Phone |
|---|---|---|

## Person Responsible for Account if Patient is a Minor

| Name | Relationship | Home Phone ( ) | Work Phone ( ) |
|---|---|---|---|

## Friend or Relative Not Living with you for Emergency Contact

| Name | Relationship | Home Phone ( ) | Work Phone ( ) |
|---|---|---|---|

## Physician Information (this is not your Endocrine Physician)

| Primary Care Physician | Clinic Name | Clinic Phone Number |
|---|---|---|
| Referring Physician | Clinic Name | Clinic Phone Number |

## Insurance Information - Bring insurance card(s) to every appointment.

| **Primary Insurance Company** | Insurance Payer Phone Number |
|---|---|

Street Address | City | State | Zip

| Group Number | ID Number |
|---|---|

| Subscriber's Name (Policy Holder) | Subscriber's Date of Birth |
|---|---|

| **Secondary Insurance Company** | Insurance Payer Phone Number |
|---|---|

Street Address | City | State | Zip

| Group Number | ID Number |
|---|---|

| Subscriber's Name (Policy Holder) | Subscriber's Date of Birth |
|---|---|

| Is there another Health Benefit Plan? Yes ___ No ___ | Name of Insurance Company |
|---|---|

**Patient Name:**_____________________________________________ **Date of Birth:**________________

**Release of Medical Information:**

If you would like us to be able to give medical information to someone other than yourself, please complete the following authorization. I authorize the physicians and staff of the Endocrinology Clinic of Minneapolis, PA to communicate with the following persons regarding my medical care:

| Printed Names of Family Member/Legal Representative/Other Specified Person | Relationship (Spouse/Significant Other/Parent/ Other Specified Person) |
|---|---|
| ________________________________________ | __________________________________________ |
| ________________________________________ | __________________________________________ |

If a name is not provided, Medical information will not be released to personal representatives.

I authorize the Endocrinology Clinic of Minneapolis, PA to leave the following information on my home answering machine (check all that applies):

___ Scheduling of Appointments/Procedures ___ Medical Information ___ Billing Information

I understand this authorization will be valid until revoked in writing.

**Medicare Authorization:**
I request that payment of authorized Medicare benefits be made on my behalf to Endocrinology Clinic of Minneapolis for services furnished me by the clinic. I authorize any holder of medical information about me released to Medicare and its agent, any information needed to determine these benefits payable for related services. I permit a copy of this to be used in place of the original.

**Assignment of Benefits:**
I hereby authorize payment of medical benefits to Endocrinology Clinic of Minneapolis for services rendered to myself and/or dependents. The signature below shall suffice for all insurance forms on a continuing basis.

**Record Release:**
I hereby authorize the release of any medical and/or billing information to my referring or primary physicians, hospitals and/or insurance company on behalf of myself and/or dependents for treatment, payment or health care operations.

**Referrals and Prior Authorizations:**
I understand that I am responsible for complying with the rules and regulations of my insurance company regarding Referral and Prior Authorization requirements. Failure to pay co-payments at time of service may result in a $20 billing fee. I agree to pay the Endocrinology Clinic of Minneapolis, PA for all charges for services not covered by Medicare or any insurance payer.

**Signed:** _________________________________________ **Date:** _________________________

I have an Advance Medical Directive (pre-written instructions regarding future health care wishes in the event I am not able to make an informed decision about my health care): Yes ___ No ___

I have a living will: Yes ___ No ___ I have a durable power of attorney: Yes ___ No ___

**Notice of Privacy Practices:**
I acknowledge that I have been given the opportunity to review and/or receive a copy of the information contained in the Notice of Privacy Practices for the Endocrinology Clinic of Minneapolis.

____________________________________________________ **Date:** _________________________
**Signature of Patient or Legal Representative**

**Please Provide us with your Current Insurance Cards:**

___ I do NOT have insurance ___ Patient will submit insurance – Bill Patient