NEW HOPE CRYSTAL MEDICAL CLINIC

3501 North Douglas Drive Crystal, MN 55422 (763) 535-9601 (763) 535-5601 Fax

PATIENT REGISTRATION

PATIENT INFORMATION

Last Name:____First Name & Middle Initial:_________________________________

Minor Child-Mother's Name:___________________________________Father's Name:___________________________________

Street Address:____

City:____State:_______________Zip Code:___________________

Home Tel #___________________________Cell Phone #___________________Email Address:_________________________

Date of Birth:______________________________Age:___________Sex: ____Female ____Male

Martial State: _________Single _____________ Married _______Other Social Security #:_______________________________

Employers Name:____ Telephone #:___________________________________

Employer Address____

City:____ State:______________Zip Code:____________________

Emergency Contact:____

Name Relationship Phone #

May we leave a message on your ____home phone ____work phone _cell phone

RESPONSIBLE PARTY/GUARANTOR INFORMATION: (Must be completed if different from patient information)

Guarantor's Last Name:________________________________ First Name & M.I.:____

Relationship to patient: ___Self ____Spouse ____ Legal Dependent __Other (specify)__________________________________

Street Address:____

City:_________________________________ State:_____________Zip Code:____________ Telephone #:___________________

Date of Birth:_____________________________________Social Security #____

Responsible Party Employer:___________________________________ Telephone #:_____________________________________

Employer Address:____

City:____ State: _______________ Zip Code:_________________

INSURANCE INFORMATION:

Primary Insurance Name:_________________________________ Policyholder Name:____________________________________

Insurance Address:_______________________________________ City:________________ State:________ Zip Code:_______

Policyholder Date of Birth:________________________________ Policy #:____________________ Group #:_______________

Secondary Insurance Name:________________________________ Policyholder Name:_____________________________________

Insurance Address:_______________________________________ City:________________ State:________ Zip Code:_______

Policyholder Date of Birth:________________________________ Policy #:____________________ Group #:_______________

Patient/Guarantor Signature for Assignment of Benefits & Records Release:

I hereby assign, transfer, and authorize payment directly to New Hope Crystal Medical Clinic any and all rights, title, interest, and medical reimbursement benefits under my insurance policy. I authorize release of any medical information needed to determine these benefits or required for medical care. This authorization shall remain valid until I give written notice revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by my insurance plan.

Patient Signature:____ Date:____________________________________