MINNESOTA SURGICAL ASSOCIATES
REGISTRATION FORM

Acct. # _____

Date: _____

PATIENT INFORMATION

Referring Doctor _____ Family Doctor _____ Clinic Name/Phone _____

Patient Name: _____ Known by any other name: _____
LEGAL LAST NAME LEGAL FIRST NAME MIDDLE NAME

Date of Birth: _____ Sex: ☐ M ☐ F Soc. Sec. No.: _____-_____-_____ Marital Status: ☐ S ☐ M ☐ D ☐ W Other_____

Address: _____
STREET CITY STATE ZIP COUNTY

Hm Phone No.:(_____)_____ Wk Phone No.:(_____)_____ Cell Phone No.:(_____)_____

Employer Name: _____ Employer Address: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Retired ☐ Unemployed ☐ Active Military ☐ Other

Emergency Contact (someone not living with you): _____ Day Phone No.:(_____)_____

PERSON RESPONSIBLE FOR THIS ACCOUNT

NAME ☐ If same as patient "x" box and skip this section	RELATIONSHIP TO PATIENT ☐ Spouse ☐ Parent ☐ Guradian ☐ Other		SOC. SEC. NO.
ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE		BIRTHDATE
EMPLOYER	ADDRESS		

INSURANCE/MEDICAL COVERAGE

1 PRIMARY INSURANCE COMPANY NAME AND ADDRESS (Street, City, State, Zip Code)

POLICY NO. GROUP NO. SUBSCRIBER SUBSCRIBER D.O.B. RELATIONSHIP TO PATIENT

2 SECONDARY INSURANCE COMPANY NAME AND ADDRESS (Street, City, State, Zip Code)

POLICY NO. GROUP NO. SUBSCRIBER SUBSCRIBER D.O.B. RELATIONSHIP TO PATIENT

WORK RELATED INJURIES ☐ Did you fill out a first report of injury Date of injury _____ INJURY CLAIMS

WORK COMP CARRIER CLAIM # WORK COMP PHONE #

PLEASE SIGN BELOW

MEDICAL INFORMATION RELEASE: I hereby authorize Minnesota Surgical Associates to discuss my medical information with the following persons:

_____

Date: _____ Signed: X _____

RECORDS RELEASE: I hereby authorize the release of any information, including medical and billing information, by Minnesota Surgical Associates, P.A. to my referring doctor, insurance company, or myself, and immediate family on my behalf and/or dependents.

Date: _____ Signed: X _____

ASSIGNMENT OF BENEFITS: I hereby authorize payment of Medical Benefits to Minnesota Surgical Associates, P.A., for services rendered to myself and/or my dependents. I guarantee payment of balances after insurance.

Date: _____ Signed: X _____

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made to me or on my behalf to Minnesota Surgical Associates, P.A., for any services furnished me by that physician/supervisor. I authorize any holder of hospital or medical information about me to release to the Center for Medicare & Medicaid and its agents and information needed to determine these benefits or the benefits payable for related service. I permit a copy of this authorization to be used in place of the original.

Date: _____ Signed: X _____