

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

Crown Medical Center – Brooklyn Park, MN

## REGISTRATION FORM

Today's date:		PCP:							
<b>PATIENT INFORMATION</b>									
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:									

<b>INSURANCE INFORMATION</b>											
<b>(Please give your insurance card to the receptionist.)</b>											
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			

<b>IN CASE OF EMERGENCY</b>							
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			