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:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital status (circle one) ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ 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):	☐ Dr.	☐ Insurance Plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ 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? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( ) -

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ (Insurance Company Name)

☐ Welfare *(Please provide coupon / card)* ☐ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $ .00

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ 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*