

To be completed by St Cloud Medical Group:

Initials: \_\_\_\_\_ Chart # \_\_\_\_\_ Account # \_\_\_\_\_ New Patient: Yes \_\_\_ No: \_\_\_\_\_

Revised 05-21-03

## **ST. CLOUD MEDICAL GROUP PATIENT INFORMATION FORM**

### **PRIMARY INSURANCE INFORMATION:**

Patient's **Legal** Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

First Middle Last

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Phone #: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ Social Security #: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

Work Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_ Do You Have Health Insurance? Yes \_\_\_ No \_\_\_

Name of Insurance: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Co-Pay: \$ \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

Relationship to Policy Holder: Self \_\_\_ Spouse \_\_\_ Dependent \_\_\_ Type of coverage: Single \_\_\_ Family \_\_\_

Policy Holder's Employer's Name & Complete Address: \_\_\_\_\_

### **SECOND INSURANCE INFORMATION: (If Applicable)**

Name of insurance: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

Relationship to Policy Holder: Self \_\_\_ Spouse \_\_\_ Dependent \_\_\_ Type of coverage: Single \_\_\_ Family \_\_\_

Policy Holder's Employer's Name & Complete Address: \_\_\_\_\_

### **EMERGENCY CONTACT: (Prefer someone out of household)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone#: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ Ext. \_\_\_\_\_

### **IF PATIENT IS A MINOR:**

Mother's Name: \_\_\_\_\_ Phone#: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ Ext. \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone#: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ Ext. \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Guardian's Name: \_\_\_\_\_ Phone#: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ Ext. \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

### **STATEMENT OF FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION: (Required if age 18 or older)**

I hereby authorize, from this day forward, any insurance company whom I subscribe with to pay directly to St. Cloud Medical Group charges for services rendered. I authorize St. Cloud Medical Group to disclose information necessary to: provide, coordinate or manage my care, including third parties such as other physicians, physical therapy, home care, etc; obtain payment for services such as determination of eligibility of services, review for medical necessity, utilization review, prior authorization, referral, admission, etc.; support business activities such as outside transcription, etc.; and notify others involved in my care if I am unable to agree or object to such a disclosure and it is determined to be in my best interest. **I understand that I am responsible for all charges made to me and/or my families account and it's my responsibility to notify the SCMG of any changes pertaining to my insurance coverage and/or my account.**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent, Guardian or Representative if Patient under 18

\_\_\_\_\_  
Date