721 Snelling Avenue South
St. Paul, MN 55116
651-690-1311

PATIENT INFORMATION FORM
Please Print

Patient's Name: ______________________________
First | Middle Initial | Last

Birth Date: ______ ______ ______
Month | Day | Year

Address: ______________________________ ______
Street | Apt.

______________________ ______ ______
City | State | Zip Code

Home Phone: (_____) ______ - ________
Work Phone: (_____) ______ - ________
Cell Phone: (_____) ______ - ________
Employer: ______________________
Social Security #: _____ - ____ -_______
Occupation: ______________________

How Did You Hear About Our Clinic? ______________________

INSURANCE/PAYMENT INFORMATION

Name Of Primary Insurance Carrier: ______________________
Secondary Coverage (If applicable): ______________________
Group Policy Number: ______________________
Co-Pay Amount: ______________________
Identification Number: ______________________
Person Responsible For The Bill: ______________________ __________
Name | Telephone #

Address:______________________ **Relationship:** ______________________

If you have private insurance, or no insurance, please indicate your method of payment today:
CASH ____ **CHECK** ____ **CREDIT CARD** ____

May we have your authorization to contact Commerce or Insurance Commissioner on your behalf if your insurance carrier needlessly delays processing of your insurance claim?
Yes ____ **No** ____

EMERGENCY INFORMATION
Nearest Relative Not Living With You: ______________________
Telephone Number: ______________________

Nearest Friend Not Living With You: ______________________
Telephone Number: ______________________

Emergency Contact: ______________________
Telephone: ______________________

Clinic Hours: Monday – Friday 9:00 AM – 5:00 PM