

To be completed by St Cloud Medical Group:

Initials: _____

Chart # _____

Account # _____

New Patient: Yes _____ No _____

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) _____ (Work) _____ Social Security #: _____

Do You Have Health Insurance? Yes _____ No _____

Name of Insurance: _____ Effective Date: _____

Policy/ID #: _____ Group/Account #: _____ Copay: Yes _____ No _____ Amt. \$ _____

Relationship to Policy Holder: Self _____ Spouse _____ Child _____ Type of Coverage: Single _____ Family _____

Name of Policy Holder: _____ Social Security #: _____

Names of Family Members Covered Under This Policy: _____

Policy Holder's Employers Name & Complete Address: _____

IF THIS IS A CHANGE IN INSURANCE:

Name of Previous Insurance: _____ Date Insurance Expired: _____

Name of Policy Holder: _____ Policy Holders Phone #: _____

Is this visit due to a work injury? Yes _____ No _____ *If yes, please complete workers compensation forms.*

Is this visit due to an automobile accident? Yes _____ No _____ *If yes, please complete automobile insurance forms.*

SECOND INSURANCE INFORMATION: (If applicable)

Name of Insurance: _____ Effective Date: _____

Policy #: _____ Group #: _____ Copay: Yes _____ No _____ Amt. \$ _____

Name of Previous Insurance _____ Date Insurance Expired: _____

Name of Policy Holder: _____ Policy Holders Phone #: _____

Relationship to Policy Holder: Self _____ Spouse _____ Child _____

Policy Holder's Employer: _____ Type of Coverage: Single _____ Family _____

If Family, Names of Others Covered Under This Policy: _____

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. This also applies to Medicare, a Health Maintenance Organization's and/or any other third party payers. Regulations pertaining to MEDICARE and other third party payers' assignment of benefits apply. I authorize St Cloud Medical Group, it's employees, or agents, to release to the Social Security Administration and Health Care Financing Administration/intermediaries, Medicare, or other insurance carriers any information necessary for processing insurance claims. **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 is under 18

Date