Account #
For Internal Use

DATE:

Surgical Specialists of Minnesota, P.A

REGISTRATION INFORMATION

Please check the Dr. you are seeing today.
- ☐ Tor Aasheim, MD
- ☐ Margit Bretzke, MD
- ☐ Daniel Dunn, MD
- ☐ Eric Johnson, MD
- ☐ Casandra Anderson, M.D
- ☐ Dawn Johnson, M.D
- ☐ Lisa Bojado, NP

REFERRING PHYSICIAN: ____

REFERRING PHYSICIAN TELEPHONE #:________________________________

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	AGE	SOCIAL SECURITY #

HOME ADDRESS	CITY	STATE	ZIP	SEX: ❑ MALE ❑ FEMALE

HOME #	WORK #	MARITAL STATUS ❑ MARRIED ❑ SINGLE ❑ DIVORCED ❑ SEPARATED ❑ WIDOWED	SPOUSE'S NAME

EMPLOYMENT INFORMATION

PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT:			OCCUPATION (Job Title)	EMPLOYMENT OR STUDENT STATUS:
PATIENT'S EMPLOYER'S OR SCHOOL ADDRESS:	CITY	STATE	ZIP	❑ FULL-TIME ❑ NOT EMPLOYED ❑ RETIRED ❑ PART-TIME ❑ SELF EMPLOYED ❑ ACTIVE MILITARY

EMERGENCY INFORMATION

FOR EMERGENCY SOMEONE NOT LIVING WITH YOU				RELATIONSHIP
EMERGENCY ADDRESS	CITY	STATE	ZIP	PHONE

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY NAME LAST FIRST MI				RESPONSIBLE PARTY HOME PHONE
RESPONSIBLE PARTY ADDRESS	CITY	STATE	ZIP	RESPONSIBLE PARTY SOCIAL SECURITY #
RESPONSIBLE PARTY EMPLOYER		OCCUPATION (Job Title)		RESPONSIBLE PARTY WORK PHONE
RESPONSIBLE PARTY EMPLOYER ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY ❑ SELF ❑ SPOUSE ❑ SON ❑ DAUGHTER

INSURANCE INFORMATION

PRIMARY INSURANCE	CARDHOLDER	DATE OF BIRTH
GROUP NUMBER	IDENTIFICATION NUMBER	

ADDRESS	CITY	STATE	ZIP

SECONDARY INSURANCE	CARDHOLDER	DATE OF BIRTH
GROUP NUMBER	IDENTIFICATION NUMBER	

ADDRESS	CITY	STATE	ZIP	PHONE

FOR WORK RELATED, MVA:

AREA TO BE TREATED ____ PLEASE CIRCLE: Right Left Both

Is this an injury: Yes No Date of Injury _______________ PLEASE CIRCLE: Work MVA TPL

DATE OF INJURY OR ACCIDENT: ____________________________

INSURANCE COMPANY: ____

ADDRESS: ____

CONTACT NAME: ____

CONTACT PHONE: ____

CLAIM #: ____

EMPLOYER CONTACT: ____

EMPLOYER PHONE: ____

PLACE OF INJURY (TPL Only): ____

IMPORTANT SIGNATURES

Please print patient name: ______________________________

FINANCIAL POLICY
You are responsible for providing us with accurate insurance information. If we do not have accurate insurance information you will be responsible for all fees. All payments are due within 30 days of receiving a statement.

ASSIGNMENT OF BENEFITS
I hereby authorize direct payment to Surgical Specialists of Minnesota, PA of any medical benefits otherwise payable to me for services provided by Surgical Specialists of Minnesota, PA.

RECORDS RELEASE
I hereby authorize Surgical Specialists of Minnesota, PA to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payer.

NOTICE OF PRIVACY PRACTICES
My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices. If you would like to authorize a family member or significant other to speak with a physician or nurse, regarding your health information, list their information here.

Contact Name: ______________________ Relationship: ______________________

Telephone Number: ______________________________

HOW CAN WE CONTACT YOU (check all that apply)

			Number	Contact You	Leave a Message
☐ Yes	☐ No	By mail			
☐ Yes	☐ No	Home Phone Number:			
☐ Yes	☐ No	Cell Phone Number:			
☐ Yes	☐ No	Work Phone Number:			
☐ Yes	☐ No	Fax Number:			

These forms have been explained to me. I have been given an opportunity to ask questions about them.

X ____
Signature of Patient/Client or Personal Representative Date

If signed by personal representative, relationship to patient: ______________________