REGISTRATION mncome

Date:	Date of Birth:	Sex:
Last name:	First name:	MI:
Address:	City: State:	Zip:
Primary phone: (home □ cell □ work □)	Secondary phone: (home □ cell □ work □)	
Social Security Number:	Marital status:	Spouse's name:
E-mail:	Employment status: full time part time unemployed retired	
	Student status: full time part time not a student	

EMERGENCY INFORMATION

Contact name:	Phone:
Relationship:	DOB:

PRIMARY INSURANCE

Insurance name:		
Identification number:	Group/Account number:	
Policy holder : self □		
If other than self: Last name:	First name:	MI:
Phone number:	Date of Birth:	Relationship:

SECONDARY INSURANCE

Insurance name:		
Identification number:	Group/Account Number:	
Policy holder: self □		
If other than self: Last name:	First name:	MI:
Phone number:	Date of Birth:	Relationship:

PROVIDER & PHARMACY INFORMATION

Referring physician: (none □)	Clinic name:	Location:
Primary physician: (none □)	Clinic name:	Location:
Pharmacy of choice:	Street & City:	Phone:

ASSIGNMENT OF BENEFITS: I hereby authorize direct payment to Minnesota Center for Obesity, Metabolism & Endocrinology, PA of any medical benefits payable to me for the services provided at Minnesota Center for Obesity, Metabolism & Endocrinology, PA.

RECORDS RELEASE: : I. I hereby authorize Minnesota Center for Obesity, Metabolism & Endocrinology, PA to release my records to my insurance company 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. **II.** I am aware that the HIPAA Privacy Rule permits health care providers that are covered entities to disclose protected medical information with each other for treatment purposes/care coordination without patient authorization.

NOTICE OF PRIVACY PRACTICES: My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices.

_____ Date:_____