Minneapolis Clinic of Neurology

WELCOME

Thank you for choosing the Minneapolis Clinic of Neurology, Ltd. for your healthcare.

Patient Information

Last First MI

Patient Name: | **Birth Date:** **Age:** | **Sex: M / F**

Other Name: (Maiden/Legal/Previous) | **Status:** Single / Married / Divorced / Separated / Widow

Street City State Zip

Address:

Phone Numbers: Home Cell Work

E-mail:

Employer:

Primary Language: | **Ethnicity:** (Circle One) Hispanic/Latino / Not Hispanic/Latino / Declined / Unknown

Race: (Circle One)

American Indian/Alaska Native -- Asian -- African American -- Native Hawaiian/Pacific Islander -- White -- Other Race -- Unknown -- Declined

Referring Physician: | **Clinic Name:**

Pharmacy Name Street City State Zip Phone Number

Preferred Pharmacy:

◯ Please check to authorize Minneapolis Clinic of Neurology to exchange electronic communications with your pharmacy.

Emergency Contact: _____ **Relationship:** _____

Primary Phone: _____ **Work Phone:** _____

Primary Insurance - Insurance companies require this information for billing purposes. Please give copy of card to Registration.

Insurance Company: | **Policy #:** | **Group #:**

(MM/DD/YYYY) (MM/DD/YYYY)

Name of Policy Holder: | **Policy Holder Date of Birth:** | **Coverage Effective Date:**

Secondary Insurance - Insurance companies require this information for billing purposes. Please give copy of card to Registration.

Insurance Company: | **Policy #:** | **Group #:**

(MM/DD/YYYY) (MM/DD/YYYY)

Name of Policy Holder: | **Policy Holder Date of Birth:** | **Coverage Effective Date:**

Workers' Compensation or Accidental Injury Information

Type of Claim: (Circle One) Workers' Compensation / Auto / Other: _____

Street City State Zip

Name of Insurance: | **Address of Insurance:**

(MM/DD/YYYY)

Claim Number: | **Date of Injury:** | **Employer at time of injury:**

Contact Person and Phone Number: | **Attorney Name and Phone Number:**

Signature

I agree to accept financial responsibility for charges not covered (or denied) by my third party or Workers' Compensation insurance.

Signature Date

PLEASE PRESENT YOUR INSURANCE CARDS AT EACH VISIT. THANK YOU!