

Account # <i>For internal use</i>	Eagan Child and Family Care	DATE _____ _____ _____	INITIAL _____ _____ _____
REGISTRATION INFORMATION			
DATE			

PATIENT INFORMATION					
LAST NAME	FIRST NAME	MI	BIRTHDATE	SOCIAL SECURITY #	
HOME ADDRESS		CITY	STATE	ZIP	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SPOUSE'S NAME		HOME #	WORK #		MARRIED STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED
EMAIL ADDRESS					
MOTHER'S NAME (If minor)		MOTHER'S BIRTHDATE	FATHER'S NAME (If minor)		FATHER'S BIRTHDATE

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			RESPONSIBLE PARTY WORK PHONE
RESPONSIBLE PARTY WORK ADDRESS		CITY	STATE	ZIP		RELATIONSHIP TO RESPONSIBLE PARTY <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER

EMPLOYMENT INFORMATION					
PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT:			OCCUPATION		EMPLOYMENT OR STUDENT STATUS: <input type="checkbox"/> FULL-TIME <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> SELF EMPLOYED <input type="checkbox"/> PART-TIME <input type="checkbox"/> RETIRED <input type="checkbox"/> ACTIVE MILITARY
PATIENT'S EMPLOYER'S OF SCHOOL ADDRESS					
CITY		STATE	ZIP		

EMERGENCY INFORMATION						
NEXT-OF-KIN – Other than spouse				RELATIONSHIP		
NEXT-OF-KIN ADDRESS		CITY	STATE	ZIP		NEXT-OF-KIN PHONE

INSURANCE INFORMATION						
PRIMARY INSURANCE		SOCIAL SECURITY #		CARDHOLDER		DATE OF BIRTH
GROUP NUMBER				IDENTIFICATION NUMBER		
ADDRESS			CITY	STATE	ZIP	PHONE
SECONDARY INSURANCE			CARDHOLDER			DATE OF BIRTH
GROUP NUMBER			IDENTIFICATION NUMBER			
ADDRESS		CITY	STATE	ZIP		PHONE NUMBER

ASSIGNMENT OF BENEFITS AND COLLECTIONS POLICY	RECORDS RELEASE
<p>ASSIGNMENT OF BENEFITS I hereby authorize direct payment to Eagan Child and Family Care, P.A. of any medical benefits payable to me for the services provided at Eagan Child and Family Care, P.A. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due any bills if this is not done.</p> <p>COLLECTIONS I understand Eagan Child and Family Care will make every attempt to process my insurance claims. If there are any monies due by myself that are not paid within 90 days they will be considered for collections. If my account is turned over to collections there will be an additional charge of up to 35%.</p>	
<p>X _____ Patient Signature or Signature of Guardian or Parent Date</p>	
<p>RECORDS RELEASE I hereby authorize Eagan Child and Family Care, P.A. 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 payor.</p>	
<p>X _____ Patient Signature or Signature of Guardian or Parent Date</p>	