

CHART NO. _____

PATIENT INFORMATION RECORD

ACCOUNT NO. _____

IN ORDER TO FILE INSURANCE, THIS FORM MUST BE FULLY COMPLETED.

PATIENT PERSONAL INFORMATION

Name _____ Age _____ Birth MO / DAY / YR _____

Mailing Address _____

City and State _____ Zip Code _____

Telephone No. (AREA CODE) _____ Patient Social Security No. _____ - _____ - _____

CIRCLE: Male Female | CIRCLE: Single Married Widowed Separated Divorced

Father's Name _____ Father's Date of Birth MO / DAY / YR _____

Mother's Name _____ Mother's Date of Birth MO / DAY / YR _____

BILLING INFORMATION

_____ (responsible party) Relationship _____

Mailing Address _____ Telephone No. (AREA CODE) _____

City and State _____ Zip Code _____

INSURANCE INFORMATION

Under whose name is the insurance policy _____

Insurance Company's Name _____ Effective Date _____

Insurance Company's Mailing Address _____

City and State _____ Zip Code _____

Contract No. _____ Group No. _____

Do you have additional health insurance? YES NO If yes,

Insurance Company's Name _____

Insurance Company's Mailing Address _____

City and State _____ Zip Code _____

Contract No. _____ Group No. _____

Are you on Medical Assistance? YES NO If yes, what county? _____ YOUR MEDICAID NO. _____

ADULT PATIENT or PARENT OF CHILD INFORMATION

Patient's Employer _____ Occupation _____

Employer's Mailing Address _____ Telephone No. (AREA CODE) _____

City and State _____ Zip Code _____

Spouse's Name _____ Date of Birth MO / DAY / YR _____

Spouse's Employer _____ Telephone No. (AREA CODE) _____

Spouse's Social Security No. _____ - _____ - _____

Nearest Friend/Relative Name _____
(other than spouse) AREA CODE
Telephone No. (AREA CODE) _____

INSURANCE AND PAYMENT AUTHORIZATION

I authorize the release of all medical information necessary to process any insurance claims filed on my behalf. I authorize direct payment of my insurance payments to Mid Dakota Clinic, P.C.

Signature _____ Date MO / DAY / YR _____

(PATIENT OR LEGAL GUARDIAN)

IF YOU ARE A NEW PATIENT TO MID DAKOTA CLINIC

How did you come to select Mid Dakota Clinic for your health care? (Please circle one of the following:)

recommendation of a friend or relative

telephone book advertisement

referred to Mid Dakota Clinic by:

newspaper advertising

(Doctor) _____

newcomer packet sent to you

Other: (please indicate) _____
