ENTIRA FAMILY CLINICS
PATIENT REGISTRATION FORM

Motor Vehicle or Liability Accident Information

Patient Name: _____ Birthdate:_____ Age: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (H)_____ (W)_____

Date of Injury:_____ Accident Details:_____

_____

UNDER MINNESOTA NO FAULT, YOUR AUTO INSURANCE IS RESPONSIBLE FOR PAYING MEDICAL CLAIMS

Insured's Name: _____ Claim NO: _____

Your Automobile Insurance Co: _____ Policy No: _____

Billing Address: _____ City: _____ State: ____ Zip: _____

Claim Rep/Contact Name_____ Phone No: _____

PERSONAL INSURANCE INFORMATION

Primary Insurance: _____ Group No: _____ ID#: _____

Subscriber's Name: _____

RELEASE OF RECORDS: I hereby authorize the release of any information by Entira Family Clinics to my referring doctor and/or insurance company, to secure the payment of benefits.

_____ _____

Date Signature

ASSIGNMENT OF BENEFITS: I authorize payment of the amount due me in my pending insurance claim be made directly to Entira Family Clinics for services rendered to myself. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.

_____ ___

Date Signature