

Johnson
Street
Medical Clinic

2904 Johnson Street NE ♦ Minneapolis, MN 55418 ♦ (612) 782-0900 ♦ (612) 788-4930

Date _____ Account Number _____
(Office Use Only)

Patient's Name _____
LAST FIRST MIDDLE INITIAL

Date of Birth _____ Sex _____ Social Security Number _____

Home Address _____

City _____ State _____ Zip Code _____

Parent _____ Social Security Number _____
(if patient is under 18)

Home Phone (____) _____ Work Phone (____) _____

Employer _____

Primary Insurance _____ Group # _____ Contract # _____

Does your insurance have a co-pay? ___ YES ___ NO If YES, the amount _____

Name of insurance subscriber _____

Relation of patient to insurance subscriber (self, spouse, dependent) _____

In case of emergency notify (other than Spouse) _____

Relationship _____ Phone (____) _____

RCORDS RELEASE: I hereby authorize the release of any information by Johnson Street Medical Clinic for services rendered to my referring doctor, insurance company, employer (pre-employment physicals only), and immediate family on behalf of myself and/or dependents.

DATE: _____ SIGNED: _____

ASSIGNMENT OF BENEFITS: I hereby authorize payment of medical benefits to Johnson Street Medical Clinic, for services rendered to myself, spouse and/or dependents. In consideration of services provided, I am agreeing to pay for services provided to me, my spouse, and to my minor children. I/WE agree to pay all charges not covered by insurance.

DATE: _____ SIGNED _____