



PATIENT INFORMATION			PLEASE PRINT		Date	Chart #
Patient's Name (Last)	(First)	(Middle)	(Maiden Name)		Birthdate	Age
Home Address					City	State Zip
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number		Home Phone ()	Work Phone ()	
Patient Relationship to Responsible Party <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other			Name of Employer			
Occupation			Employer's Address			
City			State		Zip	
Friend or Relative Not At Same Address			Address		Phone ()	
Email Address			Cell Phone ()			
Has any other Family Member been a patient of Northwest Family Physicians? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Name			Relationship			

BILLING INFORMATION			(Information about the person that is responsible to pay for what is not paid by insurance - The Guarantor)			
Guarantor's Name (FIRST)	(MIDDLE INITIAL)	(LAST)	(PREVIOUS LAST)		Birthdate	Age
Guarantor's Home Address			City		State Zip	
Patient's Relationship to Guarantor <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other			Guarantor's Social Security Number		Guarantor's Home Phone Number ()	
Guarantor's Occupation			Name of Guarantor's Employer		Guarantor's Work Number ()	
					Guarantor's Cell Phone ()	

BILLING INFORMATION			(Complete if patient is under 18)			
Mother's Name			Date of Birth		Social Security No.	
Home Address			City		State Zip	
Employer					Home Phone ()	
					Work Phone ()	
Father's Name			Date of Birth		Social Security No.	
Home Address			City		State Zip	
Employer					Home Phone ()	
					Work Phone ()	

INSURANCE INFORMATION						
Primary Insurance:		Group #	Identification #			
Policy Holder:		Effective Date:				
Secondary Insurance:		Group #	Identification #			
Policy Holder:		Effective Date:				

CLINIC CREDIT INFORMATION: You will receive a monthly statement and ask that you pay your account in full each month. If accounts are not paid 90 days after service, your balance will be subject to a finance charge of 1% per month, which is the equivalent of 12% annually. The above information is true and correct and is hereby given to the clinic for the purpose of receiving medical care. I understand the above policies and agree to pay for such treatment under the terms of the clinic as outlined.
 YES ___ NO* ___ INITIALS ___

ASSIGNMENT OF BENEFITS: I hereby authorize that payment due me in my pending insurance claim be made directly to NW Family Physicians, P.A. Payment is authorized upon your receipt of an itemized statement of services.
 YES ___ NO ___ INITIALS ___

AUTHORIZATION FOR RELEASE FOR RESEARCH OR QUALITY IMPROVEMENT: Minnesota Law requires us to inform you that your medical records, no matter when created, may be released for research or quality improvement purposes unless you object. I authorize this release and agree I may revoke this agreement at anytime in writing delivered to the clinic. I may also inquire about whether such a release has been requested.
 YES ___ NO ___ INTIALS ___

RECORDS RELEASE: I hereby authorize NW Family Physicians, P.A. to release my referring physician, and insurance company any information, including diagnosis and records of treatment concerning my past and current medical history.
 YES ___ NO ___ INTIALS ___

SIGNATURE _____ DATE _____
 *If no, patient responsibilities are to be paid in full at time of service.