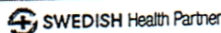


Patient Registration Form

Patient Label or MRN

MINOR & JAMES
MEDICAL



PATIENT INFORMATION

Name (Last, First Middle)		Alias/Maiden	
Birthdate / /	Soc Sec #: -- --	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Address		City	State Zip
Primary Phone		Work Phone	Other Phone
<input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Other:		<input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American/Inuit <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Decline	Religion (specific to medical needs or requirements): None <input type="checkbox"/>
<input type="checkbox"/> Needs interpreter Language:		Primary Care Physician:	
Employer	Occupation <input type="checkbox"/> Retired	Emergency Contact	Phone Relationship

BILLING & INSURANCE INFORMATION

Guarantor (person responsible for bill)		Same as patient <input type="checkbox"/>	
Name (Last, First Middle)		Alias/Maiden	
Birthdate / /	Soc Sec #: -- --	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to patient
Address		Apt	City State Zip
Employer		Occupation <input type="checkbox"/> Retired	Primary Phone Alternate Phone
Primary Insurance Provider:		Secondary Insurance Provider:	
Group: ID:		Group: ID:	
Subscriber: Same as patient <input type="checkbox"/>		Subscriber: Same as patient <input type="checkbox"/>	
Birthdate / /	Copay(s)	Birthdate / /	Copay(s)
Soc Sec #: -- --	Relationship to patient	Soc Sec #: -- --	Relationship to patient
Employer <input type="checkbox"/> Retired		Employer <input type="checkbox"/> Retired	

INITIALS:

INITIALS:

INITIALS:

INITIALS:

CONSENT TO CARE: I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known.

NOTIFICATION OF RELEASE FOR PAYMENT: I understand that Minor & James Medical will disclose any diagnosis and pertinent information to the extent required to assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment for HIV/AIDS, sexually transmitted diseases, substance abuse or mental health conditions.

FINANCIAL AGREEMENT: I understand co-payments are due at the time of service. I assign payment from my insurance directly to Minor & James Medical. I understand I am financially responsible to Minor & James Medical for the charges not paid by insurance and that those charges are due within 30 days of invoice. I understand that in addition to the bill from my provider I may also receive separate bills from the laboratory, radiology and other specialized services. If co-pays are not collected at the time of service, MJM may charge a \$10 billing/administrative fee.

RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES: I have received a copy of the Minor & James Notice of Health Information Practices which provides information about how my health information may be used and disclosed.

Signature ☐ Signed by patient ☐ Signed by parent/guardian

Date

Printed name of parent/guardian

Relationship to patient

SEE OTHER SIDE ►

Medicare Patients: In order to process your claim properly, Medicare requires us to gather information regarding your current Medicare eligibility. We will need to verify this information with you every 90 days. Please answer the following questions:

		YES	NO
Medicare #:	<input type="checkbox"/> Part A Date: / / <input type="checkbox"/> Part B Date: / /		
Are you over 65 years of age and is this why you have Medicare Part B benefits?		<input type="checkbox"/>	<input type="checkbox"/>
Are you employed right now?		<input type="checkbox"/>	<input type="checkbox"/>
Is your spouse employed right now?		<input type="checkbox"/>	<input type="checkbox"/>
Are you covered by a health plan from your own or family member's current employment?		<input type="checkbox"/>	<input type="checkbox"/>
Does the employer have 20 or more employees?		<input type="checkbox"/>	<input type="checkbox"/>
Are you or your spouse retired?	Your retirement date: / /	<input type="checkbox"/>	<input type="checkbox"/>
Spouse's name: _____	Spouse's retirement date: / /		
Do you have Medicare because of end stage renal disease (ESRD)?		<input type="checkbox"/>	<input type="checkbox"/>
Is ESRD the reason you first became eligible for Medicare?		<input type="checkbox"/>	<input type="checkbox"/>
Are you within the first 30 months of treatment for ESRD?		<input type="checkbox"/>	<input type="checkbox"/>
Is the reason you have Medicare due to a disability, other than ESRD?		<input type="checkbox"/>	<input type="checkbox"/>
Are you covered by a group health plan of an employer with over 100 employees?		<input type="checkbox"/>	<input type="checkbox"/>
Has the Department of Veterans Affairs (VA) authorized and agreed to pay for the services at this facility today?		<input type="checkbox"/>	<input type="checkbox"/>
<i>VA benefits are separate from TRICARE medical coverage. "Yes" means the VA sent you here today.</i>			
Were you a coal miner and entitled to benefits under the Federal Black Lung Program?		<input type="checkbox"/>	<input type="checkbox"/>
Is this illness or injury due to a work related accident, and will your bill today be sent to a Workers' Compensation Carrier primary to or instead of Medicare		<input type="checkbox"/>	<input type="checkbox"/>
Is this illness or injury the result of a non-work related accident (i.e. motor vehicle accident)?		<input type="checkbox"/>	<input type="checkbox"/>
Do you have non-fault or liability insurance (i.e. auto insurance) that we should bill instead of Medicare for your services today?		<input type="checkbox"/>	<input type="checkbox"/>
Are services to be paid by a government research program?		<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please provide billing instructions to the front desk.</i>			

Claim Info		CLAIM OR POLICY #:	
Employer/Auto Insurance Company Name or State L&I		<input type="checkbox"/> Claim Manager Assigned	<input type="checkbox"/> Attorney Involved
Claim Address		Name	Name
City	State Zip	Phone	Phone
This claim is older than 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No I have PIP Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Injury Info		Injured body part:	
Date of Injury / /	Time of Injury : <input type="checkbox"/> AM <input type="checkbox"/> PM		
Place of injury	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other	<input type="checkbox"/> Work-related accident/illness (L&I)	
Address		Company Name	
City	County State Zip	<input type="checkbox"/> Motor vehicle accident (MVA)	
Name/Clinic of referring physician (<input type="checkbox"/> I have been treated by this doctor for this injury?)		<input type="checkbox"/> Crime Victim <input type="checkbox"/> Other	
		Phone	