

Update  
 Dr. Becker  \_\_\_\_\_

# Minneapolis Orthopaedics, Ltd.

Account # \_\_\_\_\_

Date \_\_\_\_\_

## Patient Information Current Complaint \_\_\_\_\_

Last Name		First	Middle Initial		
Address			City	State	Zip
Home Phone	Work Phone		Cell Phone or Pager		E-mail
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed		Social Sec.#		Birthdate
			Spouse name	Spouse Birthdate	Spouse Social Sec.#
Referring Physician		Address			Phone

<b>Responsible Party Information</b>			Relationship		
Name			Date of Birth		Home Phone
Address		City	State	Zip	Social Sec.#
Employer's Name			Work Phone		

<b>Nearest Relative or Friend not Living with You</b>			Relationship		
Name			Phone		
Address			City	State	Zip

<b>Insurance Information</b>					
Primary Insurance		Address			
Policy holder Name/Employer if Workers' Compensation		ID# / Claim #		Group #	
Secondary Insurance/Private Health or Health Insurance		Address			
Policy Holder Name		ID # / Claim #		Group #	

<b>Accident Information</b>			<input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Liability		Date of Injury
Attorney Name			Attorney Phone		
Attorney Address			City	State	Zip
Insurance Adjuster Name			Phone		

**Assignment of Benefits and Guarantee of Account**  
I hereby authorize payment directly to Minneapolis Orthopaedics, Ltd. of benefits otherwise payable to me, including major medical insurance, agreeing that this assignment is irrevocable. I also authorize refund to the insurance carrier of overpaid insurance benefits where my coverages are subject to coordination of benefits. I authorize any overpayment due me on this account to be first applied to any other unpaid balance I may have at Minneapolis Orthopaedics, Ltd. I understand that I am financially responsible to Minneapolis Orthopaedics, Ltd. for all charges incurred. I agree to pay this account when due.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Records Release and Privacy Notice**  
I hereby authorize Minneapolis Orthopaedics, Ltd. to release to my referring physician and insurance company any information, including diagnosis and records of treatment, concerning my past medical history and orthopaedic care. I have been provided with a copy of Minneapolis Orthopaedics, Ltd. Notice of Privacy Practice.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Medicare Patient Signature Authorization**  
I requested that payment of authorized medicare benefits be made to Minneapolis Orthopaedics, Ltd. for any services furnished me by that clinic. I authorize any holder of hospital or medical information, about me to release to the Health Care Financing Administration and its agents any information needed to determine the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signed \_\_\_\_\_ Date \_\_\_\_\_