☐ Dr. Becker ☐ _____

Minneapolis Orthopaedics, Ltd.

Account #_____
Date _____

Patient Information

Current Complaint_____

Last Name	First	Middle Initial	☐ Smoker ☐ Non Smoker

Address	City	State	Zip

Home Phone	Work Phone	Cell Phone	Pager	E-mail

Sex ☐ M ☐ F	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow	Social Sec.#	Birthdate

Race	Primary Language	Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino	Spouse name	Spouse Birthdate	Spouse Social Sec.#

Referring Physician	Address	Phone

Responsible Party Information

Name	Relationship	Date of Birth	Home Phone

Address	City	State	Zip	Social Sec.#

Employer's Name	Work Phone

Nearest Relative or Friend Not Living with You

Name	Relationship	Phone

Address	City	State	Zip

Insurance Information

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 #

Accident Information

☐ Auto ☐ Work ☐ 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_____