

# MINNESOTA VOICE & SPEECH CLINIC

## Patient Registration Sheet

Appointment Date \_\_\_\_\_ Time \_\_\_\_\_

**Welcome. Please print and complete this confidential form to assist us in helping you and caring for the problem/issue you identify in the form below.**

Patient Name	
Birthdate	
Address	
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Phone	
Cell phone	
Work phone	
E-mail	
Problem/Issue	
Referring Physician	
Clinic	
Primary Physician	
Clinic	
Name of Party Responsible for charges	
Address	
Home Phone	

Work Phone	
Employer	
Patient is	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (relationship? _____)
Whom can we notify in case of emergency?	(Name) _____ (Phone number) _____

Primary Insurance	Secondary Insurance
Ins. Co. _____	Ins. Co. _____
Policy Holder _____	Policy Holder _____
Group/Plan # _____	Group/Plan # _____
ID/Contract # _____	ID/Contract # _____
Effective date _____	Effective date _____

I authorize the evaluation and/or treatment of my: Self, Child, Spouse, Dependent at Minnesota Voice & Speech Clinic \_\_\_\_\_ (Initial)

I authorize the release of any medical information necessary to process these medical claims. \_\_\_\_\_ (Initial)

I authorize payment of medical benefits to be made directly to Minnesota Voice & Speech Clinic. \_\_\_\_\_ (Initial)

I understand that I have the right to keep all my information confidential. \_\_\_\_\_ (Initial)

**I understand that I am responsible for all charges regardless of Insurance coverage.**

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