

FREMONT COMMUNITY HEALTH SERVICES, INC.

REGISTRATION FORM

Central Avenue Clinic
 2610 Central Ave. NE
 Minneapolis, MN 55418
 612-781-6816

Fremont Clinic
 3300 Fremont Ave. N
 Minneapolis, MN 55412
 612-588-9411

Sheridan Women & Children's Clinic
 342-13th Ave. N.E.
 Minneapolis, MN 55413
 612-362-4111

Chart # _____	Patient Information	Date _____
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Name (First, M.I., Last): _____ Social Security #: _____

Date of Birth: _____ Sex: M F Marital Status: S M W D

Address: (Street) _____ (City) _____ (State) _____ (ZIP) _____

Phone #: _____ Alternate Phone #: _____ Driver's License #: _____

Employer: _____ Work #: _____

Employer's Address: _____

If Student, School Name: _____ Full / Part Time _____

Responsible Party Information If Different From Above

Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security #: _____

Address: _____

Phone #: _____ Alternate Phone #: _____ Driver's License #: _____

Employer: _____ Work #: _____

Employer's Address: _____

In Case of Emergency Contact
 Friend/Relative Not Living with You. Name: _____ Phone #: _____

Do you have a living will/Medical Directive? Yes or No If Yes, Date Filed _____

Does Your Insurance Cover medications? Yes or No

For funding reports only, no names are disclosed. (Please Circle) Race:

Afri-Amer. Asian/Pacific Isl. Latino/Hisp. Native American/Alaskan Native White, not Hispanic Other Multiracial

Primary Language: _____

(Turn Over Please)

Primary Insurance Information

Medicare #:	Medicaid #:	
Insurance Co.:	Phone #:	
Insurance Address:		
Group #:	Certificate or ID #:	
Insured's Name:	Relationship to Patient: Self / Spouse / Dependent	
Insured's Employer:	Phone #:	
Employer's Address:		
Insured's Social Security #:	Date of Birth:	Sex: Male / Female

If the patient is covered by another insurance policy, please complete the following information for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank you!

Secondary Insurance Information

Medicare #:	Medicaid #:	
Insurance Co.:	Phone #:	
Insurance Address:		
Group #:	Certificate or ID #:	
Insured's Name:	Relationship to Patient: Self / Spouse / Dependent	
Insured's Employer:	Phone #:	
Employer's Address:		
Insured's Social Security #:	Date of Birth:	Sex: Male / Female

I hereby assign, transfer, and set over to Fremont Community Health Services all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I give written notice revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____