# NORTHSTAR SLEEP CENTER
# PATIENT REGISTRATION

## PATIENT INFORMATION

Patient's Last Name | First | Middle | ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. | Marital Status ❑ Sgl ❑ Mar ❑ Div ❑ Sep ❑ Wid

Is this your legal name ? ❑ Yes ❑ No | If not, what is your legal name ? | (Former Name) | Birth Date | Age | Sex ❑ M ❑ F

Race | Hispanic / Latino ❑ Yes ❑ No

Street Address | City | State | Zip Code | Social Security No. | Home Phone No. ( )

P.O. Box | City | State | Zip Code | Cell Phone No. ( )

Occupation | Employer | Employer Phone No. ( )

Employment Status:
FT ❑ PT ❑ Self Employed ❑ Military ❑ Not Employed ❑ | Email Address

NAME OF PRIMARY CARE PHYSICIAN & CLINIC
Referring Physician | Physician Phone Number: ( )

How were you referred? ❑ Physician ❑ Family/Friend ❑ Website ❑ Billboard ❑ Ads

## INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill: | Birth Date: | Address (if Different): | Home Phone No. ( )

Is this person a patient here ? ❑ Yes ❑ No

Occupation: | Employer: | Employer Address: | Employer Phone No. ( )

Is this patient covered by insurance ? ❑ Yes ❑ No

Please indicate primary insurance: ❑ BLUE CROSS ❑ HEALTHPARTNERS ❑ PATIENT CHOICE ❑ MEDICA CHOICE ❑ MEDICARE (B) ❑ UCARE FOR SENIORS ❑ UCARE ❑ WORK COMP ❑ MN/MA ❑ Other ____________

Subscriber's Name: | Subscriber's Social Security # | Birth Date: | Group # | Policy # | Co-Payment $

Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other____________

Name of Secondary Insurance (if applicable): | Subscriber's Name: | Group #: | Policy #:

Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other____________

## IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address) | Relationship to Patient: | Home Phone No. ( ) | Work Phone No. ( )

The above information is true to the best of my knowledge, I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize NorthStar Sleep Center to release any information required to process my claims.

X ______________________________________________

PATIENT/GUARDIAN SIGNATURE DATE

## ATTENTION:

All patients under Managed Care with a primary care clinic with insurance plans listed below **will need referrals:**

- Aetna Managed Choice
- Blue Plus
- Blue Cross
- Patient Choice
- HealthPartners
- Medica Premier
- Medica Elect
- Medica Advantage Plan
- Medica Primary (MSHO Dual Solutions)
- Preferred One PCP
- Select Care POS
- Ucare
- Other plans needing referrals

You are required to bring your referral with you at the time of your visit or have your primary care clinic fax the referral to Minnesota Lung Center / Minnesota Sleep Institute at 952-567-7414 prior to your visit. If you are part of Fairview Physicians Associates or Minnesota Healthcare Network, a written referral is not required.

All co-pays must be paid at time of visit or a $5.00 late fee will be charged.

If you have any questions, please contact our business office at 952-567-7409.