EDINA SPORTS HEALTH & WELLNESS, P.A.

NAME First	Middle Initial	Last	Birthdate
Address	City	State	Zip Code
Home Phone ( )	Bus./Cell Phone ( )	Social Security	
Employment Status **(please circle one)** **FT PT Self-Employed Unemployed Retired**		Spouse's SS #	
Occupation	Employer/School Name	Student Status **(please circle one)** **FT PT**	
Marital Status **(please circle one)** **M S W D**	Spouse/Parent's Name	Spouse/Parent's Employer	
Spouse/Parent's Bus Phone	Person Responsible For This Account		

Primary Ins Co. Name	Street Address		
Group/Account#	Contract/ID #	Ins Effective Date	
Subscriber Name	Sex **(please circle one)** **M F**	Birthdate	
Subscriber Address	City	State	Zip Code
Subscriber Phone	Relationship to Subscriber		
Subscriber's Employer	Employer's Address		
Employer's City	State	Zip Code	Employer Phone

Secondary Ins Co. Name	Street Address		
Group/Account#	Contract/ID #	Ins Effective Date	
Subscriber Name	Sex **(please circle one)** **M F**	Birthdate	
Subscriber Address	City	State	Zip Code
Subscriber Phone	Relationship to Subscriber		
Subscriber's Employer	Employer's Address		
Employer's City	State	Zip Code	Employer Phone

RECORDS RELEASE: I herby authorize the release of any information, including medical and billing information, by **EDINA SPORTS HEALTH & WELLNESS, P.A.,** to my referring doctor and/or insurance company.

Date:_____ **Signed: X**_____

ASSIGNMENT OF BENEFITS: I herby authorize payment Medical Benefits to **EDINA SPORTS HEALTH & WELLNESS, P.A.,** for services rendered to myself and/or dependents.

Date:_____ **Signed: X**_____

FINANCIAL RESPONSIBILITY: I understand and agree that I am ultimately responsible for the balance of my account for any services rendered.

Date:_____ **Signed: X**_____

MEDICARE AUTHORIZATION: I request payment of authorized Medicare benefits be made to me or on my behalf to: **EDINA SPORTS HEALTH & WELLNESS, P.A., for** any services furnished to me by that physician/clinic/supervisor. I authorize any holder of hospital or medical information about me to be released to the Health Care Financing Administration and its agent, any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Date:_____ **Signed: X**_____