

Minor Med, Inc.

1119 Gage Blvd, Topeka, KS 66604

Phone: (785) 272-4000

www.minormedtopeka.com

Patient's Name _____ Gender: M F Social Security # _____ DOB: _____
Address _____ Phone # () _____
City _____ State _____ Zip _____ Driver's License St # _____
Employer _____ Work Phone # () _____
Primary Care Physician _____ Emergency Contacts (name & number) _____

Please write below a description of your medical problem, including any relevant past medical history.

Is this a Workers' Compensation injury or Employment Physical/Drug Screen? Y N If yes, skip to reverse side.

How did you hear about us? (circle one) Website, Newspaper, Friend, Phonebook: AT&T or Fiest, Other _____

Insurance Information

Insured's Name: _____ Insured's SS# _____ Insured's DOB: _____
Insured's Address: _____ Relationship to Patient _____
Name of Insurance Co: _____ ID# _____ Group # _____
Insurance Company Address _____ Co-pay Amount _____

Responsible Party Information (please fill out if patient is under 18 years of age)

Responsible Party: _____ Social Security # _____ DOB: _____
Home Address _____ Phone # () _____
City _____ State _____ Zip _____ Driver's License # _____
Employer _____ Work Phone # () _____

How are you paying today? (check one) Cash Check Visa/MC/Discover

If you do NOT have insurance that we contract with, we require full payment at time of service!

If you do have insurance we require that you pay your co-pay or co-insurance at time of service

Medicare/Medicaid: We are sorry, but effective 7/1/1998 Minor Med is not longer a Medicare provider. We can no longer see patients who are insured through Medicare/Medicaid/Tricare/Unicare even if they are the patient's secondary form of insurance or the patient wishes to pay for the entire office visit.

Policy: The person who brings a child in for treatment may also be responsible for fees incurred that day. I am the responsible party of the patient and hereby authorize release of the above information. I understand that regardless of any insurance coverage I am responsible for payment of services. I authorize Minor Med, Inc. to release any medical or billing information to any of my insurance carriers to aid in processing claims. I also authorize payment to go directly to Minor Med, Inc. for any claims submitted by them. I further understand that I am expected to pay my co-pay or deductible portion at the time of service. I am responsible for knowing my insurance coverage deductibles and co-pay policies.

I Acknowledge that I have received a copy of the Provider's Notice of Privacy Practices with the effective date of April 14, 2003.
I have read and completed this form fully and completely, and certify I understand its contents.

Signature _____ Date _____

Persons to whom you authorize Minor Med to release information to: _____
Authorized's Name _____ Date Authorized: _____ Date Rescinded: _____

Office use only

Time Arrived: _____ AM / PM