

# Minor Med, PA

1119 SW Gage Blvd, Topeka KS 66604

Phone: (785) 272-4000

www.minormedtopeka.com

Patient's name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_  Male  Female  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Driver's License # \_\_\_\_\_ State \_\_\_\_\_ Home # (\_\_\_\_) \_\_\_\_\_ Cel # (\_\_\_\_) \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_  
Primary Care Physician (First and Last Name) \_\_\_\_\_ Email \_\_\_\_\_  
Emergency contact name and # \_\_\_\_\_

Have you been to Minor Med before? Yes / No

How did you hear about us? Phone Book TV Radio Newspaper Friend Family Other: \_\_\_\_\_

Please write below a brief description of the reason for your visit today, including any relevant past medical history.

Is your visit today a **workers' compensation** injury or employment-related physical/ drug screen? **Yes / No**  
**If YES, please fill out WC form**

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

Responsible Party: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Street Address \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Driver's License # \_\_\_\_\_ Drivers License state \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

**A Note to the Responsible Party:** The person who brings a child in for treatment may also be responsible for fees incurred that day. By signing this form, you agree that you are the responsible party of the patient(s) and that regardless of any insurance coverage you are responsible for payment of services. You authorize Minor Med, Inc. to release any medical or billing information to any of my insurance carrier(s) to aid in processing claims. You also authorize payment to go directly to Minor Med, PA for any claims submitted by them. You further understand that you are expected to pay your co-pay or deductible portion at the time of service. You are responsible for knowing your insurance coverage, deductibles and co-pay policies.

**Name of Insurance** (Please list primary insurance first, if applicable) \_\_\_\_\_  
**Primary Policy Holder's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
**Policy Holder's Address** \_\_\_\_\_  
**ID#** \_\_\_\_\_ **Group#** \_\_\_\_\_ **Co-pay** \_\_\_\_\_

***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 payment of your co-pay at time of service.***

How are you paying today?  Cash  Check  Visa /MC /Discover

- **Medicare/Medicaid/Champus Patients:** Effective 7/1/98 Minor Med opted out of the Medicare program. We can no longer see patients who are insured by Medicare, Medicaid, Champus, Tricare or Healthwave even if they are secondary or wishes to pay for the entire office visit.

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of 5/202008. I have read and completed this form fully and completely, and I certify that I understand its contents.

Date: \_\_\_\_\_ Signature \_\_\_\_\_

Persons to whom you authorize Minor Med to release information to: \_\_\_\_\_

**For Office Use Only.**

Attach to Medical Record

**Time:** \_\_\_\_\_ **AM/PM**