



PATIENT CHECK-IN FORM

Clinic ID:

Clinic Location:

Date/Time: _____

First Name: _____

Gender: Female / Male (circle one)

Last Name: _____

Middle Initial: _____

How did you hear about MediMin Clinic?
__ Sign __ TV/Radio __ Friend/Family
__ Newspaper __ Ad __ Referred by physician

Address: _____
(No P.O. Boxes)

Do you have a primary physician? __ YES __ NO
If yes, provide name: _____
(First & Last Name)

City: _____ State: _____ Zip: _____

Physician Phone: (_____) _____ - _____

Home Phone No: (_____) _____ - _____

Would you like a referral to a PCP? __ YES __ NO

Work Phone No: (_____) _____ - _____

Reason for Visit _____

Cell Phone No: (_____) _____ - _____

E-mail: _____

Would you like to receive health tips? __ YES __ NO

Birth Date: ____/____/____

Is patient current on immunizations? __ YES __ NO

Who is responsible for payment? _____ Relationship to patient: _____

Will you be using health insurance? _____ How will you be paying for your visit today? Cash / Credit (circle one)

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Policy Number: _____ Policy Number: _____

Group Number: _____ Group Number: _____

Employer: _____ Employer: _____

Is this the patient's policy? Yes / No (circle one) Is this the patient's policy? Yes / No (circle one)

If not, who is the policy holder: _____ If not, who is the policy holder: _____

Holder's Date of Birth: ____/____/____ Holder's Date of Birth: ____/____/____

In case of emergency, notify: _____ Phone No: (_____) _____ - _____

I hereby authorize MediMin, Inc. to furnish information to insurance companies as may be requested for illness or injury. This authorization shall apply to my records or any minor listed either above or below. I authorize payment for these services be made directly to MediMin, Inc. I also understand that I am responsible for payment of services not covered by my insurance company and that payments for co-pays are required at the time of service.

Signature of responsible party: _____ Date: _____

Printed name (if not patient): _____