MINNESOTA BONE AND JOINT SPECIALISTS

JEFFREY NIPPER, M.D. • JACK BERT, M.D. • JOE BOCKLAGE, M.D.

9325 UPLAND LANE N SUITE 205, MAPLE GROVE, MN 55369
Phone: 763-416-0777 Fax: 763-416-0476

REGISTRATION FORM

PRIMARY CARE PHYSICIAN:	Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status (circle one) Single / Married / Divorced / Separated / Widow

(Former name):	Primary phone no.: ( )	Secondary phone no.: ( )	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ______________________________

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other ❑ Insurance Plan	❑ Hospital

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance:	

Subscriber's name:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Other family members seen here:

WORK COMP OR AUTO INSURANCE

Is this a Work Comp Injury? ❑ Yes ❑ No Claim # Adjustor Name/Phone #

Insurance Company		Billing Address	

Is this an Auto Accident? ❑ Yes ❑ No Claim # Adjustor Name/Phone #

Insurance Company		Billing Address	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature: Date:

MINNESOTA BONE AND JOINT SPECIALISTS

JEFFREY NIPPER, M.D. • JACK BERT, M.D. • JOE BOCKLAGE, M.D.

9325 UPLAND LANE N SUITE 205, MAPLE GROVE, MN 55369
Phone: 763-416-0777 Fax: 763-416-0476

Patient Name____ Birthdate____________

The Patient/Guardian authorizes Minnesota Bone and Joint Specialists to contact them at

Primary Phone_______________________ Alternate Phone_______________________

Primary Phone	Alternate Phone
( ) May leave detailed message	( ) May leave detailed message
( ) May leave call back number only	( ) May leave call back number only

What is your primary language spoken? English –or- Other___________________________

Will you need an interpreter? (   ) Yes (   ) No

Often times following surgery or appointments it may be necessary for spouses, family members or others to receive/obtain medical health information on your behalf. Please list below any individuals who are authorized to receive/obtain information from Minnesota Bone and Joint Specialists. Parents/Guardians of minors do not need to list their name(s) below. Minnesota Bone and Joint Specialists reserve the right to contact or speak to others no listed on this list if we feel the situation is an emergency.

Minnesota Bone and Joint Specialists is authorized to disclose information about the patient to:

Spouse/Significant Other Name: ____

Family Members/Friends:
Name: _______________________________________ Relationship: ________________

Name: _______________________________________ Relationship: ________________

Patient/Guardian Signature: ________________________________ Date: ___________

This authorization will be in effect until patient revokes in writing