



SOUTHDALE ALLERGY AND ASTHMA CLINIC

4010 W 65th Street, #221, Minneapolis, MN 55435

Phone (952) 926-7630 - Fax (952) 926-2116

Name (Last) _____ (First) _____ (M.I.) _____

Birth date _____ Age _____ SS# _____ Sex _____

Address _____ City _____ St _____ ZIP _____

Occupation _____

Phone (H) (_____) _____ (W) (_____) _____

Person to be billed _____ Relationship _____

Whom may we thank for referring you? _____

Referring Doctor _____ Clinic _____

Family Doctor _____ Clinic _____

Insurance Company _____

Insured _____ Relationship _____

Birth date _____ Employer _____

Insurance ID # _____ Group # _____

Other Insurance _____

Record Release: I hereby authorize the release of any information concerning my examination or treatment by Southdale Allergy and Asthma Clinic to my referring doctor, my family doctor, and insurance companies on behalf of myself and/or dependents.

Assignment of Benefits: I hereby authorize payment of medical benefits to Southdale Allergy and Asthma Clinic for services rendered to myself and/or dependents. I understand that I am responsible for any amount not covered by insurance.

Medicare Patients: I request that payment of authorized Medicare benefits be made either to me or, on my behalf, to Southdale Allergy and Asthma Clinic for any services furnished me by this clinic. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents 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: _____ Signature: _____

Annual renewal of release and authorization:

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____