Benson Area Medical Center

( ) Mr. ( )Mrs. ( ) Ms. ( ) Miss

Last Name_____ First Name_____ Middle _____

Date of Birth _____ Social Security Number _____

Race: ( ) American Indian or Alaska Native ( )Asian ( ) Black or African American

( ) White ( ) Native Hawaiian or Other Pacific Islander ( ) Declined

Ethnicity: ( ) Hispanic or Latino ( ) Non-Hispanic or Latino ( ) Declined

Marital Status: ( ) Married ( ) Single ( ) Separated ( ) Divorced ( ) Widowed ( ) Declined

Your Benson Area Medical Center Provider (who do you see?)_____

Address_____

City_____ State _____ ZIP_____

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

Best Phone to Contact _____Email_____

Policy Holder Name _____ Relationship to Patient_____

Policy Holder's Date of Birth _____

Emergency Contact _____Relationship to patient _____

Phone _____

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT: I authorize treatment of the person named above. I authorize the release of any medical information necessary to process insurance claims. I request payment to government benefits or other insurance agency benefits to be made to the Physicians or facility for services performed. It is agreed that if payment is not made by insurance, I will be held liable (this includes lack of payment due to insurance deductibles, lapse of coverage, or preexisting conditions). Notice: Do not sign this agreement before you have read and agree with the conditions set forth above.

_____ Date:_____

This institution is an equal opportunity provider and employer.