Avera Medical Group Windom
820 2nd Avenue
P.O. Box 338
Windom, MN 56101
(507) 831-1703 • Fax (507) 831-5668

Patient Payment Information

Please fill out completely or we will not be able to file your insurance.

Patient Information

Name (last)_____ First_____ MI_____

Address_____ City_____ State_____ Zip _____

Date of Birth_____ Sex ❑ M ❑ F SS# _____

Occupation_____ Employer_____

Phone (home)_____ (work)_____ Marital Status ❑ S ❑ M ❑ D ❑ W

Notify in case of emergency:_____ Phone:_____

Children: Name _____ M F BD _____

Name _____ M F BD _____

Name _____ M F BD _____

Name _____ M F BD _____

Name _____ M F BD _____

Party Responsible for Payment (if different than patient information)

Name (last)_____ First_____ MI_____

Address_____ City_____ State_____ Zip _____

Date of Birth_____ Sex ❑ M ❑ F SS# _____

Occupation_____ Employer_____

Phone (home)_____ (work)_____ Marital Status ❑ S ❑ M ❑ D ❑ W

Insurance

(1) Name of Insurance Company _____ ID # _____

Address _____ Group # _____

Subscriber _____ Date of Birth_____

Subscriber's Employer _____

Patient Relationship to Subscriber _____

Subscriber's SS #:_____ Subscriber's Sex: ❑ M ❑ F

(2) Name of Secondary Insurance Company _____ ID # _____

Address _____ Group # _____

Subscriber _____ Date of Birth_____

Patient's Relationship to Subscriber_____

I request payment of authorized benefits be made on my behalf to United Medical Clinic for any services furnished me by United Medical Clinic. I authorize my holder of medical information to release insurance carriers any information needed to determine benefits payable for services provided. I understand that I am responsible for any amount not covered by insurance.

Patient Signature:_____ Date: _____

Form 7391-02 PS (Rev. 2/04)