721 Snelling Ave S
St. Paul, MN 55116
Phone: 651-690-1311
Fax: 651-690-5274

PARKWAY CLINIC

INSURANCE & BILLING INFORMATION

Patient Legal Name:

_____ _____ ____
Last Name First Name MI

Date of Birth: _____

What is your race/ethnicity?
(Please select all that apply)

__ American Indian, Alaska Native or Indigenous
__ Asian
__ Black or African American
__ Hispanic or Latino/Latina/Latine
__ Native Hawaiian or Pacific Islander
__ White
__ Prefer to self-describe_____
__ Prefer not to specify

What is your preferred Language? _____

Patient Insurance Information

Insurance Carrier: _____ Group Number: _____

ID Number: _____

Health Insurance Policy Holder:
(If policy holder is the patient, skip this and sign below)

Name: _____ Relation to Patient: _____

Date of Birth: _____

Address: _____

City: _____ State: ____ Zip: _____ Phone number: _____

Signature of Patient/Authorized Representative _____

Relationship to Patient: ☐ Self
☐ Other: _____ **Date: _____**

OFFICE USE ONLY **(please complete reverse side)**

Entered By: _____ Chart # _____

REQUIRED FORM