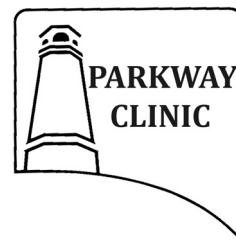


721 Snelling Ave S  
St. Paul, MN 55116  
Phone: 651-690-1311  
Fax: 651-690-5274



## 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