Patient Registration Information

Form content retained in medical record.
Discard after electronic entry.

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*	
Birth Date *(mm-dd-yyyy)*	Room Number (if applicable)
Mayo Clinic Number	

If you have ever been a patient at Mayo Clinic, you will have a medical record on file.
Indicate if you have ever received care from:

- ☐ Mayo Clinic physician or provider
- ☐ Mayo Clinic or Mayo Clinic Hospital in Rochester, Minnesota, Methodist Campus, or Saint Marys Campus
- ☐ Mayo Clinic or Mayo Clinic Hospital Florida
- ☐ Mayo Clinic or Mayo Clinic Hospital Arizona
- ☐ Mayo Clinic Health System site

Additional Patient Information

Suffix	Salutation *(Mrs., Mr., Ms., Miss)*	Sex	Marital Status	Social Security Number
Permanent Address *(Street, City, State, ZIP Code, Country)*				
Where are you staying locally?	Local Phone	Dates You Will Be at This Address *(mm-dd-yyyy)*		
Home Phone	Mobile Phone	Email	Fax	
Race	Ethnicity	Religious Affiliation	Patient Needs	Preferred Communication
What language do you feel most comfortable speaking with your doctor or nurse?	If not English, do you require an interpreter? ☐ Yes ☐ No			
Employer Name	Address *(Street, City, State, ZIP Code, Country)*			
Work Phone	Occupation	Employment Status	Date Retired (if applies) *(mm-dd-yyyy)*	

Spouse, Emergency Contact, Next of Kin, or Guarantor (for minors), if Applicable

Name *(First, Middle, Last)*	Birth Date *(mm-dd-yyyy)*	Relationship to Patient	
Address *(Street, City, State, ZIP Code, Country)* ☐ Same as above	Home Phone	Mobile Phone	
Language	Interpreter needed? ☐ Yes ☐ No	Employment Status	Date Retired (if applies) *(mm-dd-yyyy)*
Additional Contact Name *(First, Middle, Last)*	Interpreter needed? ☐ Yes ☐ No	Phone	Relationship to Patient

Primary Insurance Information

Effective Date *(mm-dd-yyyy)*	Insurance Company Name	Group Number	Precertification Phone
Claim Address *(Street, City, State, ZIP Code)*			
Subscriber Employer	Subscriber ID Number	Subscriber Relationship to Patient	Subscriber Birth Date *(mm-dd-yyyy)*

Additional Insurance Information

Effective Date *(mm-dd-yyyy)*	Insurance Company Name	Group Number	Precertification Phone
Claim Address *(Street, City, State, ZIP Code)*			
Subscriber Employer	Subscriber ID Number	Subscriber Relationship to Patient	Subscriber Birth Date *(mm-dd-yyyy)*

Attach a copy of the front and back of active insurance card(s).

Is this visit workers' compensation or motor vehicle related? (check one) ☐ Yes ☐ No

ENTERPRISE: Applies to Mayo Clinic locations in Arizona, Florida, Rochester and Mayo Clinic Health System.

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