



Mayo Nicotine Dependence Center Residential Treatment Program

Pre-Registration

REGISTRATION INFORMATION

To assure that Mayo has the most current information, please provide the following information as it appears on your driver's license.

Mayo Clinic Number	Patient Name – First, Middle, Last	Title <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.
Patient Home Address – Street	Birth Date (Month DD, YYYY)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
City, State, ZIP Code	County	Home Phone (with area code)
Cell Phone (with area code)	Work Phone (with area code) May we contact you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	E-mail Address
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced Maiden Name	Former Spouse Name (if divorced or widowed)	
Name of Nearest Living Relative or Friend	Home Address of Relative or Friend – Street	
Relationship	City, State, ZIP Code	
Home Phone (with area code)		

ENROLLMENT – I am requesting enrollment for the following program (select one)

PROGRAM LENGTH – <i>Please plan for a full day of medical appointments on the first Friday of the program, (appointments begin at 8 a.m.). The program ends at approximately 1 p.m. on the final Friday.</i>	2009 Program Dates <input type="checkbox"/> August 7 - 14, 2009 <input type="checkbox"/> September 11 - 18, 2009 <input type="checkbox"/> October 23 - 30, 2009 <input type="checkbox"/> December 4 - 11, 2009	2010 Program Dates <input type="checkbox"/> January 22 - 29, 2010 <input type="checkbox"/> February 19 - 26, 2010 <input type="checkbox"/> April 16 - 23, 2010 <input type="checkbox"/> June 11 - 18, 2010	<input type="checkbox"/> August 6 - 13, 2010 <input type="checkbox"/> September 17 - 24, 2010 <input type="checkbox"/> October 22 - 29, 2010 <input type="checkbox"/> December 3 - 10, 2010
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PAYMENT

A Mayo Financial Representative can assist you in determining your insurance coverage for the program. Please fill out the information requested below to assist Mayo in exploring your insurance coverage. Room, meals and aftercare calls are provided at no additional cost. However, you will be expected to purchase any medications needed for your treatment during the 8-day program. These can be brought with you or purchased locally. Please Note: To hold a program we must have a minimum of 5 confirmed participants. If we do not have 5 confirmed participants within two weeks prior to the start of the program we will cancel that program. You will be notified if cancellation occurs.

INSURANCE INFORMATION

Insurance Company Name	Insurance Benefits Company Phone (with area code)	Patient Policy ID Number
Insurance Claims Address		
Policy Holder Name	Policy Holder Birth Date	Policy Holder Policy ID Number
Attach photocopy of insurance cards both front and back. Return this form in the enclosed self-addressed stamped envelope or fax to 507-266-7236 at your earliest convenience to ensure timely enrollment. Sending this form does not guarantee enrollment. If you have questions regarding this form or general questions in regard to the Residential Program feel free to call us at 1-800-344-5984 or (507) 266-9392 or e-mail stopsmoking@mayo.edu .		Plan Number
		Insurance Identification Number