Please complete, print and submit.

MAYO CLINIC

Nicotine Dependence Center Residential Treatment Program

Reset Form

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 ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.
Patient Home Street Address	Birth Date *(Month DD, YYYY)*	Sex ☐ Male ☐ Female
City, State, ZIP Code	County	Home Phone *(with area code)*
Mobile Phone	Work Phone - May we contact you at work? ☐ Yes ☐ No	E-mail Address
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced Maiden Name		Former Spouse Name *(if divorced or widowed)*
Name of Nearest Living Relative or Friend	Relationship	Home Phone *(with area code)*
Friend/Relative Home Street Address	City, State, ZIP Code	

Enrollment

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

Program Length	**2011 Program Dates**		
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	☐ January 21 - 28, 2011	☐ April 8 - 15, 2011	☐ September 16 - 23, 2011
	☐ February 18 - 25, 2011	☐ June 17 - 24, 2011	☐ October 7 - 14, 2011
	☐ March 18 - 25, 2011	☐ August 5 - 12, 2011	☐ December 2 - 9, 2011

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	Patient Policy ID Number
Insurance Claims Address		
Policy Holder Name	Policy Holder Birth Date	Policy Holder Policy ID Number
		Plan Number
		Insurance Identification 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.**

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