NORTHERN LIGHTS PEDIATRIC & ADOLESCENT MEDICINE

Today's Date_____

•3555 Willow Lake Blvd. Suite 140; Vadnais Heights, MN 55110
•14712 Victor Hugo Blvd. Suite 40; Hugo, MN 55038

PATIENT INFORMATION

Patient Race: ___Alaskan Native or Native American
___Asian (Far East, Southeast Asia, Indian Subcontinent)
___Black or African American
___Native Hawaiian or Pacific Islander
___Hispanic or Latino
___White or Caucasian

Patient Primary Language_____ Not Hispanic_____ Hispanic _____ Birth Country_____

Patient Name_____ Sex: M__ F__ Birthdate_____
LAST FIRST MI

Primary Phone _____ □ Home □ Cell □ OK to leave messages Child's Cell Phone_____

Street_____ City_____ ST _____ Zip_____

PARENT/GUARDIAN INFORMATION

FATHER _____ Birthdate_____
__PARENT __STEP PARENT __GRANDPARENT __LEGAL GUARDIAN __OTHER

Street_____ City_____ ST _____ Zip_____

Primary Phone Number_____ □ Home □ Cell □ OK to leave messages Secondary Phone Number _____

Employer_____ Position_____ Work Phone_____

MOTHER_____ **Your Maiden Name** _____ Birthdate_____
__PARENT __STEP PARENT __GRANDPARENT __LEGAL GUARDIAN __OTHER

Street_____ City _____ ST _____ Zip_____

Primary Phone Number_____ □ Home □ Cell □ OK to leave messages Secondary Phone Number _____

Employer_____ Position _____ Work Phone_____

RESPONSIBLE PARTY (BILLING INFORMATION)

Who is the insurance policy holder: _____ DOB: _____ Relationship to patient: _____

Who should receive any bills from the clinic: _____ Relationship to patient: _____

Address (if different from above): _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone Number_____
Someone not in your house

OTHER CHILDREN LIVING AT YOUR HOME

_____ _____

_____ _____

How did you hear about our clinic_____

Family Email address:_____

Preferred pharmacy: _____ **Location of pharmacy:** _____