NORTHERN LIGHTS PEDIATRIC & ADOLESCENT MEDICINE
3555 Willow Lake Blvd Ste 140, Vadnais Heights, MN 55110

Today's Date: ______________

PATIENT INFORMATION

Patient Name: ______________________________ DOB: ____________
Last First MI

Sex assigned at birth: ________ Primary Phone __________ Child's Phone __________ Gender Identity __________

Address ______________________ City ____________ ST ______ Zip ________

Ethnicity: ____ Hispanic ____ Non Hispanic Patient's Primary Language: ____________ Country Of Birth: ____________

Patient Race:

____ Alaskan Native of Native American ____ Asian (Far East, Southeast Asia, Indian Subcontinent) ____ Black or African American
____ Hispanic or Latino ____ Native Hawaiian or Pacific Islander ____ White or Caucasian

PARENT/GUARDIAN INFORMATION

Name #1: ______________________________ DOB: ____________
___ Parent ___ Step Parent ___ Grandparent ___ Legal Guardian Other: ____________
Address ______________________ City ____________ ST ______ Zip ________
Primary Phone number: ______________ Secondary Phone Number: ______________
Employer: ______________ Position: ______________ Work Phone: ______________

Name #2: ______________________________ DOB: ____________
___ Parent ___ Step Parent ___ Grandparent ___ Legal Guardian Other: ____________
Address ______________________ City ____________ ST ______ Zip ________
Primary Phone number: ______________ 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 living in your house)

LIST OTHER PEOPLE LIVING IN YOUR HOME

______________________ ______________________
______________________ ______________________

Family Email Address: ______________________________
Preferred Pharmacy: ______________________ Location: ______________
NEW PATIENTS: How did you hear about our clinic? ______________________

Updated Date: __________ Initial: __________ Updated Date: __________ Initial: __________
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