Child

WELCOME

Minneapolis Clinic of Neurology

Thank You for choosing the Minneapolis Clinic of Neurology, Ltd. for your healthcare.

Patient Information

Patient Name: (Last / First / MI) | **Birth Date:** | **Age:** | **Sex:** (Circle One) **M / F**

Legal Name: (if different) | **Name of parent/guardian present:**

Address: (Street / City / State / Zip)

Phone Numbers: Home Cell Other

E-mail:

Primary Language: | **Ethnicity:** (Circle One) Hispanic/Latino / Not Hispanic/Latino / Declined / Unknown

Race: (Circle One)
American Indian/Alaska Native -- Asian -- African American -- Native Hawaiian/Pacific Islander -- White -- Other Race -- Unknown -- Declined

Referring Physician: | **Clinic Name:**

Preferred Pharmacy: (Pharmacy Name / Street / City / State / Zip / Phone Number)

◯ Please check to authorize Minneapolis Clinic of Neurology to exchange electronic communications with your pharmacy.

Emergency Contact: _____ **Relationship:** _____

Home Phone: _____ **Work Phone:** _____ **DOB:** _____

Responsible Party

Parent 1 Name: (Last / First / MI) | **Birth Date:** (MM/DD/YYYY) | **Phone Numbers:** **Home:** **Cell:** **Work:**

Address: (Street / City / State / Zip)

Parent 2 Name: (Last / First / MI) | **Birth Date:** (MM/DD/YYYY) | **Phone Numbers:** **Home:** **Cell:** **Work:**

Address: (Street / City / State / Zip)

Primary Insurance - Insurance companies require this information for billing purposes. Please give copy of card to Registration.

Insurance Company: | **Policy #:** | **Group #:**

Name of Policy Holder: | **Policy Holder Date of Birth:** (MM/DD/YYYY) | **Coverage Effective Date:** (MM/DD/YYYY)

Secondary Insurance - Insurance companies require this information for billing purposes. Please give copy of card to Registration.

Insurance Company: | **Policy #:** | **Group #:**

Name of Policy Holder: | **Policy Holder Date of Birth:** (MM/DD/YYYY) | **Coverage Effective Date:** (MM/DD/YYYY)

Workers' Compensation or Accidental Injury Information

Type of Claim: (Circle One) Workers' Compensation / Auto / Other: _____

Name of Insurance: | **Address of Insurance:** (Street / City / State / Zip)

Claim Number: | **Date of Injury:** (MM/DD/YYYY) | **Employer at time of injury:**

Contact Person and Phone Number: | **Attorney Name and Phone Number:**

Signature

I agree to accept financial responsibility for all charges not covered (or denied) by my third party or Workers' Compensation insurance.

Signature (Patient or Parent/Responsible Party) Date

PLEASE PRESENT YOUR INSURANCE CARDS AT EACH VISIT. THANK YOU!