Child Neurology SOLUTIONS

Patient Registration Form
Section 1

Patient (Legal) Last Name	First Name (Legal)	Preferred Name	Full Middle Name

Date of Birth	Gender	Social Security Number	Primary Care Physician	Religious Affiliation
/ /	Female___Male ___	- -		

Preferred Spoken Language	Preferred Written Language	Need an Interpreter?
		Yes or No

Ethnicity **(circle one)**	Race **(circle one)**
Hispanic or Latino / Non Hispanic or Latino or Unknown	Asian / Black African-American / Caucasian / Hawaiian-Pacific Islander Native American-Eskimo / Multi-Racial-Other / Decline to State - Unknown

Section 2

Patient Address (Number, Street, Apt #)	City	State	Zip Code
Bill To Address (if same as above, leave blank)			
Mailing Address (Number, Street, Apt #)	City	State	Zip Code

Parent or Legal Guardian Information

Parent/Legal Guardian of Minor	Date Of Birth	Relationship to Minor
	/ /	

Phone 1 **(Home, Cell, Work/Other)**	( ) -	Would you like an appointment reminder call? **Yes or No**	
Phone 2 **(Home, Cell, Work/Other)**	( ) -	Phone 3 **(Home, Cell, Work/Other)**	( ) -

Email Address	@ **.com** or **.net** or ._____ ***(circle one)***

Parent/Legal Guardian of Minor	Date of Birth	Relationship to Minor
	/ /	

Phone 1 **(Home, Cell, Work/Other)**	( ) -	Phone 2 **(Home, Cell, Work/Other)**	( ) -

Emergency Contact

Emergency Contact's Name	Relationship to patient	Phone
		( ) -

Insurance Holder Information

Insurance Holder Name (Subscriber)	Date of Birth	Relationship to Patient	Phone Number
	/ /		( ) -
	/ /		( ) -

Insurance Holder Employer Information

Employer Name & Address (Number, Street, Apt #, City, State, Zip Code)	Employer Phone Number
	( ) -
	( ) -

Do you have a copy of your insurance card with you today? Yes____ No_____ *(If no, please complete this section)*

Health Plan Information	Primary Health Plan	Secondary Health Plan
Health Plan Name		
Health Plan Address		
Phone Number	( ) -	( ) -
Subscriber Number		

Signature_____ **Relationship to Patient**_____ **Date** _____

last revised 11/2015

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ACKNOWLEDGEMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

The undersigned acknowledges he/she has received a copy of the Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information (PHI). You may also obtain a copy on our web-site at www.ChildNeurologySolutions.com or contacting our office at (651) 356-6080.

Patient/Legal Representative Signature _____ Date _____

Staff Use Only *(check box):* ☐ NOPP Offered Pt Declined to Sign ☐ Emergency Situation NOPP Not Offered