

WAYZATA CHILDREN'S CLINIC, P.A.
Patient Information Form

Patient Name – Last, First, MI
Patient's Street Address, City, State & Zip:

Sex: (circle one)	Date of Birth	Patient's Home #:	Patient's Cell #:
Male Female		()	()

Language: _____ Race/Ethnicity : _____ Country of Origin: _____

NOTE – If your care is Work Related or due to an Auto Injury, COMPLETE the form for this important information – see the Receptionist. If you are working with an attorney or expect to, please give us their name, address and telephone number.

* * IF PATIENT IS A MINOR, please fill out parent / guardian information below * *
Please Indicate Which Parent is the Policy Holder for this Child – *If this changes, please let us know. Thank you!*

Father's Full Name:	Father's Date of Birth:	Father's Work #: ()
		Father's Cell #: ()
Father's Street Address	Father's City, State & Zip:	Father's Home #: ()
Mother's Full Name:	Mother's Date of Birth:	Mother's Work #: ()
		Mother's Cell #: ()
Mother's Street Address	Mother's City, State & Zip:	Mother's Home #: ()

Local Friend/Relative <u>not</u> at same address	Telephone ()	Relationship
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- * **Treatment Authorization-** I hereby authorize Wayzata Children's Clinic, P.A., or their designee(s), to treat my or the patient's conditions as they deem appropriate.
- * **Assignment of Benefits.** I hereby assign the authorized benefits and direct that payment under any insurance policy or health benefits plan to be made directly to Wayzata Children's Clinic, P.A. for any services rendered to me or the Patient on behalf of Wayzata Children's Clinic, P.A.
- * **HIPAA/HiTECH Act-** I have received the Notice of Privacy Practices from Wayzata Children's Clinic P.A.
- * **Records Release to Insurance Carrier(s) and Other Payers-** I hereby authorize Wayzata Children's Clinic, P.A. to release to my insurance company, health plan, HMO, no-fault carrier, and/or workers' compensation carrier, any information including my complete health record needed to determine benefits for services provided by or on behalf of Wayzata Children's Clinic, P.A.
- * "I understand that I am financially responsible for charges not covered under my insurance policy".
- * **Health Forms-** I hereby authorize Wayzata Children's Clinic, P.A. to release pertinent medical record information when completing health forms for schools, daycares, sports and camp.

For the information above:

SIGNATURE **DATE**

RELATIONSHIP TO PATIENT _____