Wayzata Children's Clinic

Patient Information Form

HOW WOULD YOU PREFER TO RECEIVE COMMUNICATION FROM OUR CLINIC?
Preferred Phone # _____ *To receive text/SMS messages this number must be a cell phone.* *Message and data rates may apply*
☐ Voice call ☐ Text/SMS ☐ Both

PATIENT INFORMATION	
Patient Name:	
Date of Birth:	**Gender:**
Address:	
Patient Cell phone (if applicable)**:**	
Family E-mail Address:	
Primary Care Provider (PCP)	

Pediatrician's or Advanced Practice Provider's name

PARENT 1 INFORMATION *(Circle to Indicate Relationships to Patient)*		
Circle one: Mother Father Legal Guardian Step Mother Step Father Other:		
Name:		**Date of Birth:**
Home Phone:	**Cell Phone:**	**Work Phone:**
Address: *(if different from above)*		

PARENT 2 INFORMATION *(Circle to Indicate Relationships to Patient)*		
Circle one: Mother Father Legal Guardian Step Mother Step Father Other:		
Name:		**Date of Birth:**
Home Phone:	**Cell Phone:**	**Work Phone:**
Address: *(if different from above)*		

EMERGENCY CONTACT INFORMATION	
Name:	
Primary Phone:	**Relationship:**

PHARMACY INFORMATION
Primary Pharmacy Name:

Please bring your insurance card to your first appointment