PATIENT INFORMATION FORM

Confidential

Patient Initials: ____________

☐ Clinical Research Institute
825 Nicollet Mall, Suite 1135
Minneapolis, MN 55402
612-333-2200

☒ Clinical Research Institute
2805 Campus Dr., Suite 435
Plymouth, MN 55441
763-744-1140

PATIENT INFORMATION:

Today's Date: ____________________________ Date of Birth: ________________________ (mm/dd/yyyy)

Name: ____ Sex: M / F
First M.I. Last Maiden

Address: ____
Street (Apt.) City State Zip

Phone: Home: (____) ______________________ Work: (_____) ________________________ Cell: (_____) ____________________

Which number is best to reach you at during the day? Home Work Cell *please circle one*

E-mail: ____

Ethnicity: ☐ Hispanic, Latino, or Spanish ☐ NOT Hispanic, Latino or Spanish

Race:
- ☐ Black or African American
- White
  - ☐ European Origin
  - ☐ North African
- Asian
  - ☐ Central / South Asian
  - ☐ East Asian
  - ☐ Japanese
  - ☐ Southeast Asian
- Other
  - ☐ American Indian and Alaska Native
  - ☐ Native Hawaiian/Other Pacific Islander

Employer: ______________________________________ Occupation: ______________________________________

Person to Contact in case of Emergency: ____

Relationship to Patient: ______________________________________ Phone: ______________________________________

Name of Primary Physician: ______________________________________ Phone: ______________________________________

Clinic Name / City: ____ Fax #: ____________________________

IF PATIENT IS A MINOR:

Parent / Guardian Name: ______________________________________ Does Parent/Guardian live in same household? Y / N
First Last

Parent / Co-Guardian Name: ______________________________________ Does Parent/Co-Guardian live in same household? Y / N
First Last

Person completing this form - Relationship to Patient: Mother Father Legal Guardian *Please Circle One*

I verify that I am the Parent / Legally Authorized Representative of this individual. ______________________________________
Signature

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