Account # *For internal use*	**Dakota Child and Family Clinic** Registration Information	Date Initial _____ _____ _____ _____ _____ _____

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE	□ MALE □ FEMALE

CELL # detailed voicemail ok? ❑	HOME # detailed voicemail ok? ❑	WORK # detailed voicemail ok? ❑	**PREFERRED METHOD OF CONTACT** □ HOME □ CELL □ WORK
EMAIL ADDRESS			

HOME ADDRESS	APT #	CITY	STATE	ZIP

GUARDIAN NAME & RELATION (if minor)	GUARDIAN'S BIRTHDATE	GUARDIAN NAME / RELATION (if minor)	GUARDIAN'S BIRTHDATE

INSURANCE INFORMATION (if you provided your current insurance card(s) at arrival you may skip this section)

PRIMARY INSURANCE	IDENTIFICATION NUMBER	GROUP NUMBER

SUBSCRIBER NAME	BIRTHDATE	PRIMARY PHONE #	□ MALE □ FEMALE
SUBSCRIBER HOME ADDRESS	CITY	STATE	ZIP

SECONDARY INSURANCE	IDENTIFICATION NUMBER	GROUP NUMBER

SUBSCRIBER NAME	BIRTHDATE	PRIMARY PHONE #	□ MALE □ FEMALE
SUBSCRIBER HOME ADDRESS	CITY	STATE	ZIP

RESPONSIBLE PARTY INFORMATION (GUARANTOR)

RELATIONSHIP TO RESPONSIBLE PARTY ☐SELF ☐CHILD ☐SPOUSE ☐OTHER	LAST NAME	FIRST NAME	MIDDLE INITIAL
HOME ADDRESS	CITY	STATE	ZIP

BIRTHDATE	PRIMARY PHONE #	SECONDARY PHONE #

RACE/ETHNICITY/LANGUAGE INFORMATION

COUNTRY OF BIRTH	PREFERRED LANGUAGE	

RACE	ETHNICITY
□ NATIVE AMERICAN OR NATIVE ALASKAN □ ASIAN □ AFRICAN OR AFRICAN AMERICAN (BLACK) □ HAWAIIN OR OTHER PACIFIC ISLANDER □ EUROPEAN AMERICAN OR CAUCASION (WHITE) □ **[PREFER NOT TO DISCLOSE]**	□ HISPANIC □ NON-HISPANIC □ **[PREFER NOT TO DISCLOSE]**

NEXT OF KIN (EMERGENCY CONTACT)

FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT	PRIMARY PHONE #

ADDITIONAL INFORMATION

PREFFERED PHARMACY (INCLUDING CITY AND STREET LOCATION)	PHONE #	FAX #

SIGNATURE	RELATIONSHIP TO PATIENT	TODAY'S DATE