Fridley Children's and Teenager's Medical Center
500 Osborne Road NE-Suite 215
Fridley, MN 55432
763-236-2700 phone/763-236-2710 fax

FCTMC-Patient Demographic Form

Patient Information:

Last Name (Legal):	First Name (Legal):	Full Middle Name:	DOB:
Gender: ☐ Male ☐ Female ☐ Other	Does Child live with both parents: ☐ Yes ☐ No	If not, who is the legal guardian:	*Please submit any judgements, decrees and/or birth certificate if there are any discrepancies in legal guardianship of the child*

RACE (*please check*) ☐ White ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander ☐ Chose not to disclose ☐ Unknown

ETHNICITY (*please check*) ☐ United States ☐ Iran ☐ Iraq ☐ Laos ☐ Lebanon ☐ Mexico ☐ Russia ☐ Serbia ☐ Somalia ☐ China ☐ Declined ☐ Other:______________________

PRIMARY LANGUAGE (*please check*) ☐ English ☐ Arabic ☐ Hmong ☐ Laotian ☐ Russian ☐ Sign Language ☐ Somali ☐ Spanish ☐ Thai ☐ Urdu ☐ Chose not to disclose ☐ Other:____________________ **Does child/parent require an interpreter: Y/ N**

Patient Address:	Apt/Unit	City/State	Zip Code/County
Primary Contact Number: #______________________ Who's phone is this?____________________	☐ Home ☐ Cell ☐ Work	Primary e-mail address for patient portal access/medical records: ______________________ Who's e-mail address is this?____________________	***Appointment reminders, recommended appointments and patient follow-up will be done by means of calls, voicemail, texts and/or e-mail***

Parents/Legal Guardians:

Name:	Phone #'s:	Place of Employment:	Home address: ☐ same as above
______________________ Relationship: DOB:	______________(H) ______________(C)	______________ Work phone:__________	
Name: ______________________ Relationship: DOB:	Phone #'s: ______________(H) ______________(C)	Place of Employment: ______________ Work phone:__________	Home address: ☐ same as above

Emergency Contact (s):

Name:	Relationship:	Home phone #	Cell Phone #	Are we able to contact this person in efforts to reach your family? Y/N
Name:	Relationship:	Home phone #	Cell Phone #	Are we able to contact this person in efforts to reach your family? Y/N

Insurance:

Primary Insurance:	Primary Insured Name:	Relationship:	DOB:	ID# Group#
Secondary Insurance:	Primary Insured Name:	Relationship:	DOB:	ID# Group#

Preferences/Information:

Primary/Preferred Provider at FCTMC:	Primary Pharmacy: Name:______________City:______________ Phone Number:______________	Other siblings at FCTMC? * * *	*Hospital child was born at: *Other clinics in which patient has been seen at:

Name of person completing this form Name:	**I attest this information provided is correct and agree to clinic policies stated on back of form:** Signature: Relationship to patient:	Date:

Please read back side of form regarding important clinic policies

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FINANCIAL/CREDIT INFORMATION

In compliance with the Federal Consumer Protection Act, Fridley Children's and Teenagers' Medical Center, P.A. (FCTMC) wishes to notify you of its policies regarding the financial responsibilities associated with services rendered to you or a member of your family.

1. You must present your insurance card at each visit.
2. Co-payments assigned by your insurance carrier are due at the time of service.
3. We will furnish you with a monthly statement of your account showing the amounts billed, and any payments and credits to the account
4. We will file most insurances. You are responsible for denied claims, and all patient responsibility amounts such as deductibles as per your insurance policy.
5. Payments for services are considered due and payable at the time of service unless active insurance is presented.
6. Payments are due within 30 days of billing unless payment plan arrangements are made with our Business Office.
7. There is a returned check fee of $35.00

ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits due to me under the terms of my policy to Fridley Children's and Teenagers' Medical Center, P.A. I understand the clinic's charge may exceed the insurance company/Medicaid payment, and if greater than such, I will be responsible for paying that additional allowable amount. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to the appointment. I will be responsible for the unpaid balance due on any bills if this is not done.

RELEASE OF INFORMATION

I hereby authorize Fridley Children's and Teenagers' Medical Center, P.A. to furnish information regarding my child's health care and medical history to insurance carriers and to other medical care providers to whom I might be referred by FCTMC and to furnish any information necessary to complete any health forms I might submit on behalf of my child's school camp, athletic organization or the like.

CONTACT INFORMATION

Fridley Children's and Teenagers' Medical Center, P.A. may use my contact information for appointment reminders, follow up calls, and secure patient health information reporting through text, phone messages, and/or emails (private patient portal).

NOTICE OF PRIVACY PRACTICES

This Notice describes how the medical information about you may be used and disclosed. Please review the privacy policy attached to the new patient clip board and sign the acknowledgment below. Please let us know if you would like a copy for your records. I have read and understand the Notice of Privacy Practices: