

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:

Date: _____

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: _____

Date of Birth: _____ (mm/dd/yyyy) Social Security Number (SSN): ____ - ____ - ____

Race: _____ Hispanic or Latino Not Hispanic or Latino

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*