PRIMROSE MENTAL HEALTH PLLC

Tel. 507-613-3883 1400 Madison Avenue Suite 614 Mankato MN 56001 Fax: 360-282-1236

Registration

Client information

Last Name	First Name	MI	Date

Present Address (Street, City, State, Zip)		
Permanent Address (if different from above)		
Home Phone #	Work Phone #	Cell Phone #
Primary E-mail Address	Secondary E-mail Address	Marital Status
Date of Birth (MM/DD/YYYY)	Social Security Number	Sex ☐ M ☐ F
Employer or School if student	Address (Street, City, State, Zip)	Occupation
Emergency Contact Name	Relationship	Phone Number(s)

Insurance Information

Primary Insurance	Cardholder Name	Date of Birth
ID Number	Group Number	Group Name
Secondary Insurance	Cardholder Name	
ID Number	Group Number	Group Name

Preferred Pharmacy

Pharmacy Name	Phone (If known)
Address (Street, City, State, Zip)	

Records Release

I hereby authorize Primrose Mental Health PLLC to release my records to my insurance company for the purpose of processing my insurance claims. This authorization shall remain in effect as long as the charges are being submitted for insurance claim processing or as long as dictated by payor.

X

Patient Signature/Signature of Guardian or Parent Date