

MINNESOTA RENEWAL CENTER
Client Registration

3499 Lexington Avenue N #100, St Paul, MN 55126
Phone: 651-486-4828

General Information

Client name _____ DOB: _____ Age: _____ Today's date: _____

SSN _____ Sex: F M Spouse or partner _____

If under 16, please give parent(s) name(s) _____

Marital Status S M D W Other _____

Current status: Student Employed Unemployed Retired Other: _____

If student, are you Full Time or Part Time? FT PT School attending: _____

If working, please give Occupation and Place of Employment _____

Emergency contact _____ Relationship _____

Emergency contact Phone Number _____ Alternative Phone Number _____

If person filling out form is not client, check here: What is your relationship to client? _____

Address & Contact Information

Home Address _____

City _____ State _____ Zip _____

If you have any special instructions regarding how you would like mailed communications to be handled to ensure your confidentiality, please detail here: _____

Home phone _____ Okay to call? Y N Okay to leave message? Y N

Cell phone _____ Okay to call? Y N Okay to leave message? Y N

Work phone _____ Okay to call? Y N Okay to leave message? Y N

Email _____ Okay to email? Y N

Any special instructions when calling, leaving messages or emailing? _____

Insurance Information

Insurance Carrier: _____ Policy ID # _____ Group # _____

Policy Holder Name: _____ Policy Holder DOB: _____ SSN _____

I hereby authorize my provider at Minnesota Renewal Center to furnish the above-named insurance company all information they may request concerning my present diagnosis and treatment. I hereby assign to my provider the insurance proceeds to be credited against the total fee for service due on my account. I understand and agree that I am financially responsible for all charges whether or not they are covered by insurance.

Client Signature _____ Date _____ (____)