Patient Information sheet **Today's Date:** ______________

First Name: ____________________ Middle initial: ______ Last Name: ____________________ Sex: ☐ M ☐ F

Date of Birth: ____________________ E-mail address: ______________________________

Address: ____
ADDRESS *CITY* *STATE* *ZIP*

Home Phone: ____________________ Cell Phone: ____________________ Work: ____________________

Preferred method of communication: ☐ Home number ☐ Cell number ☐ Email Occupation: ______________

Insurance Information: ____
SUBSCRIBER NAME *DOB* *INSURANCE CARRIER* *GROUP* *ID*

If minor, who is responsible party? ____________________

Emergency Contact: ______________________________ Relationship: ______________
NAME *PHONE NUMBER*

Do we have permission to contact this person regarding matters concerning your care? ☐ Yes ☐ No

Additional Health Care Professionals (Specialist) involved in patient's care:

____
NAME *SPECIALTY* *PHONE NUMBER*

Ethnicity (check one):
- ☐ Non-Hispanic
- ☐ Hispanic
- ☐ Refused to Report

Primary Race (Check one)
- ☐ White
- ☐ Hispanic
- ☐ African American/Black
- ☐ Asian
- ☐ Native American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Other Race
- ☐ Unreported/Refused

Primary Language Spoken at Home (check one): ☐ English ☐ Spanish ☐ Other: _____ Interpreter needed? ☐ Yes ☐ No

Who is the Primary Caregiver (provides day –to-day care) for the Patient?

____
NAME *RELATIONSHIP TO PATIENT*

Who is the Legal Guardian (Individual designated by the patient, family or court to make health care decisions for the patient if the patient is unable to do so) for the Patient?

____
NAME *RELATIONSHIP TO PATIENT*

Preferred pharmacy: ____
NAME *ADDRESS* *PHONE NUMBER*

ELECTRONIC PRESCRIPTIONS*: Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorized us to do so.*

IMMUNIZATIONS: *Our electronic medical records program allows for your immunization data to be sent directly to the I-CARE State of Illinois Registry. I-CARE allows your providers to obtain your immunization history to ensure your safety. By signing this, you authorize us to submit this data.*

Signature: ____ *Date:* ______________
PATIENT GUARDIAN *RELATIONSHIP TO PATIENT*

Revised December 5, 2016