Caring Family Patient Information **Today's Date: _____**

First name: Middle initial: Last name: Sex: ☐M ☐F

Date of Birth: E-mail address_____

Address:
ADDRESS CITY STATE ZIP

Preferred Phone #: Secondary Phone #:

Marital Status: ☐Single ☐Married ☐Other: If minor, who is responsible party? _____

Insurance Company Name:_____Employer:_____

Insurance Policy Holder Name:_____Birthdate_____Male____Female_____

Relationship of policy holder to patient? self____parent____spouse_____other_____

Emergency contact: _____ Relationship: _____
NAME PHONE NUMBER

Do we have permission to discuss your healthcare with anyone else beside yourself? ☐ Yes ☐ No

If yes, whom may we leave a message with? _____relationship?_____

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

Preferred Language (check one): ☐ English ☐ Spanish ☐ Other: _____

Do you have an advanced directive such as a living will or medical power of attorney? ☐ Yes ☐ No
Is your visit with us today due to an automobile accident or work place accident? ☐ Yes ☐ No

Have you seen another doctor since your last visit with us? _____Yes _____No

---

Preferred Pharmacy #1: _____ Mail Order? ☐ Yes ☐ No
NAME ADDRESS PHONE NUMBER

Preferred Pharmacy #2: Mail Order? ☐ Yes ☐ No
NAME ADDRESS PHONE NUMBER

HIPPA NOTIFICATION: *You have been given a copy of our HIPPA (privacy practices) form. Your signature acknowledges receipt of that form.*

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 authorize us to do so.*

IMMUNIZATIONS: *Our electronic medical record 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.*

***Your signature** also authorizes us to bill your insurance company for your visits, if applicable.*

Signature: *Date:*
PATIENT/GUARDIAN RELATIONSHIP TO PATIENT