

Patient Information Sheet

Today's Date: _____

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

Date of Birth: _____ Primary Care Physician: _____

Address: _____
NAME PHONE NUMBER
ADDRESS CITY STATE ZIP

Home phone: _____ Cell phone: _____ Work: _____

E-mail address: _____

Preferred method of communication: Home number Cell number Email Other: _____

Marital Status: Single Married Other: _____ Employment Status: FT PT Retired Other N/A

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

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: _____ Interpreter Needed? Yes No

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

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

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

Current Medications

Name of Medication	Dose	Frequency Taken	Reason Taken	Prescribing Physician

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.*

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