Patient Information Sheet **Today's Date:** _____

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

Date of Birth: _____ Primary Care Physician: _____
NAME PHONE NUMBER

Social Security #_____

Patient Address: _____
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 and discuss treatment? Yes No

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

Primary race (check one):
White Asian Other Pacific Islander Hispanic
Native American Other Race
African American/Black Native Hawaiian 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
Is your condition is due to the work injury? Yes No
If YES Do you intened to file a claim related to your condition? 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
Allergies				

If you have a list of your medications, please give it to the medical assistant.

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**