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

Home phone: _____ Cell phone: _____

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

Insurance Policy Holder Name:_____Birthdate_____ Male_____Female_____

Insurance Company Name:_____

Employer_____

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

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