Patient Information Sheet

Today's Date: _____

First name: _____ Middle initial: _____ Last name: _____

Date of Birth: _____ SSN (Optional): _____

Permanent Address: _____
ADDRESS CITY, STATE, ZIP

Mailing Address: _____ ☐ Same as above
ADDRESS CITY, STATE, ZIP

Home phone: _____ Cell phone: _____ Other: _____

E-mail address: _____

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

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
Name: _____ Address: _____ Phone Number: _____
Mail Order? ☐ Yes ☐ No

Preferred Pharmacy #2
Name: _____ Address: _____ Phone Number: _____
Mail Order? ☐ Yes ☐ No

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:* _____

KIM AND CALVERT PEDIATRICS

DATE:_____

PATIENT NAME:_____

Mother's Last Name:_____ First Name:_____

DOB:__/__/____ Cell Phone:_____ Work Phone:_____

Occupation:_____ Employer:_____

Father's Last Name:_____ First Name:_____

DOB:__/__/____ Cell Phone:_____ Work Phone:_____

Occupation:_____ Employer:_____

Primary Insurance Carrier:_____

Policy Holder's Name:_____ Relationship:_____

ID#_____ Grp#:_____ Copay $_____

Secondary Insurance Carrier:_____

Policy Holder's Name:_____ Relationship:_____

ID#_____ Grp#:_____ Copay $_____

Emergency Contact (person not living in same household)

Name:_____ Relationship:_____

Phone #: _____

Person's Authorized to Bring the Patient to an Appointment:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

KIM AND CALVERT, M.D., S.C.

THIS NOTICE DESCRIBES HOW MEDCAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY.

I have received the attached Notice of Privacy Practices from the practice of Kim and Calvert, M.D., S.C.

Name of Patient_____Date_____

Parent/Guardian Signature_____

Relationship to Patient_____

Witness_____Date_____

Advocate Physician Partners

SynAPPs

HIPAA Privacy Statement - Addendum

This practice participates in a Health Information Exchange program where key clinical information about our patients' care is shared electronically, through a secure web portal, between this practice and other physicians/providers also providing care to our patients. Basic health information is shared with other treating physicians and providers. Sharing of basic health information in a Health Information Exchange is done so to have information available to better care for patients and the information is used for no other purposes.

LATER, if you decide that you no longer wish to participate, any information in The Health Information Exchange cannot be removed, but it will not be viewable because the patient identifying information will be inactivated. If you wish to exclude your basic health information from being included in this program, please inform the practice manager. You will be asked to sign a form documenting your wishes to "Opt-out".

The following information is defined by the State of Illinois as specially protected health information and should ***only***be shared with the patient's written permission in the Health Information Exchange, eEHX. This specially protected information includes information concerning alcoholism treatment, drug abuse treatment, mental health services, developmental disabilities services, genetic testing and treatment, testing and treatment for HIV/AIDS/Sexually Transmitted Disease, treatment for child abuse/neglect, and treatment of sexual assault or abuse.

We have taken precautions to try and exclude this information from the Health Information Exchange, but there still is a small possibility that this information may be inadvertently sent to the HIE. **Therefore, if you have specially protected health information you should "Opt-out" of participating in the eEHX, or sign a consent that allows release of your specially protected health information.**

This practice also participates with the **Illinois State Immunization Registry and Public Health Disease Surveillance Registry**. Information will be sent electronically to the IL State registries about immunizations and state-required reportable diseases. This information is used by the State of IL to track Public Health needs. If you do not want your immunization information to be reported to the IL State Immunization Registry you may request to "Opt out" of this by signing an Opt-out form. This will not affect your care by your doctor.