Patient Information She	<u>et</u>		Today's Date:	
First name:		_ Middle initial:		
Date of Birth:):	
Permanent Address:				
ADD	PRESS		CITY, STATE, ZIP	
Mailing Address:ADD				Same as above
ADD	PRESS		CITY, STATE, ZIP	
Home phone:	Cell phe	one:	Other:	
E-mail address:				
Preferred method of communic	cation: Home numb	er Cell number	☐ Email ☐ O	ther:
Emergency contact:NAM	<u> </u>		Rela	tionship:
Do we have permission to cont	ME act this person regardi	PHONE NUMBE ng matters concerning vo	R our care? Yes N	
Ethnicity (check one): Non-Hispanic Hispanic Refused to Report	☐ Whit		☐ Asian ☐ Native American ☐ Native Hawaiian	☐ Other Pacific Islander ☐ Other Race ☐ Unreported/Refused
Preferred Language (check one Do you have an advanced direct Is your visit with us today due Preferred Pharmacy #1 Name: Mail Order? Yes No	ctive such as a living we to an automobile accident	vill or medical power of a lent or work place accide	attorney? Yes No	rpreter Needed? Yes No
Preferred Pharmacy #2				
Name: Yes No		Address:	Phone Number	r:
Current Medications Name of Medication	Dose	Frequency Taken	Reason Taken	Prescribing Physician
	-			
ELECTRONIC PRESCRIPT for us to safely prescribe your in IMMUNIZATIONS: Our elect State of Illinois Registry. I-CAI you authorize us to submit this	meaication. By signing ctronic medical recora RE allows your provid	this, you authorize us to program allows for you	do so.	sent directly to the LCADE
Signature:			Date:	

KIM AND CALVERT PEDIATRICS

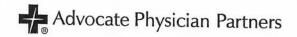
DATE:				
PATIENT NAME:				
Mother's Last Name	Eiret I	Mamor		
		Name:		
DOB:// Cell Phone:	Work	Phone:		
Occupation:	Employer:			
Father's Last Name:	First N	lame:		
DOB:/ Cell Phone:	Wor	k Phone:		
Occupation:	Employer:			
Primary Insurance Carrier:				
Policy Holder's Name:		Relationship:		
ID#	_ Grp#:	Copay \$		
Secondary Insurance Carrier:				
Policy Holder's Name:		Relationship:		
ID#	_ Grp#:	Copay \$		
Emergency Contact (person not li	iving in same househousehousehousehousehousehousehouse	old)		
Name:	Relationship:			
Phone #:				
Person's Authorized to Bring the	Patient to an Appoin	tment:		
Name:	Relationship:			
Name:	Relationship:	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	f Privacy Practices from the practice of Kim
and Calvert, M.D., S.C.	A CONTRACTOR OF THE CONTRACTOR

Name of Patient	Date	
Parent/Guardian Signature		
Relationship to Patient		
Witness	Date	





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.

Revised: January 31, 2012