MIDWEST PEDIATRICS, LTD **Patient(s) Information Sheet** Primary Care Physician: _____
NAME

1) _____ _____ ____ ___/___/___ Sex: ☐M ☐F
LAST NAME FIRST NAME MIDDLE INITIAL DATE OF BIRTH

2) _____ _____ ____ ___/___/___ Sex: ☐M ☐F
LAST NAME FIRST NAME MIDDLE INITIAL DATE OF BIRTH

3) _____ _____ ____ ___/___/___ Sex: ☐M ☐F
LAST NAME FIRST NAME MIDDLE INITIAL DATE OF BIRTH

4) _____ _____ ____ ___/___/___ Sex: ☐M ☐F
LAST NAME FIRST NAME MIDDLE INITIAL DATE OF BIRTH

Patient(s) Address: _____
ADDRESS CITY STATE ZIP

Home Number: _____ Mom Cell Number: _____

E-mail address: _____ Dad Cell Number: _____

Mother Info: _____ _____ ____ ___/___/___
LAST NAME FIRST NAME MIDDLE INITIAL DATE OF BIRTH

Home Address (if different from patient): _____
ADDRESS CITY, STATE ZIP

Father Info _____ _____ ____ ___/___/___
LAST NAME FIRST NAME MIDDLE INITIAL DATE OF BIRTH

Home Address (if different from patient): _____
ADDRESS CITY/STATE ZIP

Responsible Party/Policy Holder: _____ Relationship: _____

Employer: _____
NAME ADDRESS CITY/STATE ZIP

Social Security No: ___-___-___ Work Number: _____

Marital Status: ☐Single ☐Married ☐Other: _____

Emergency Contact (name of nearest relative not living with you) :

Name: _____ Relationship: _____ Telephone No: _____

_____
ADDRESS CITY STATE ZIP

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

Preferred Pharmacy #1: _____
NAME ADDRESS CITY PHONE NUMBER

Pharmacy #2: _____
NAME ADDRESS CITY PHONE NUMBER

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.*

I understand that I am responsible for prompt payment for the services that insurance does not cover.
I also understand that if I do not cancel my appointment within 24 hours, I may be charged $25.00 per missed appointment.

SIGNATURE: _____ **DATE:** _____
PATIENT/GUARDIAN RELATIONSHIP TO PATIENT