BLOOMINGTON PEDIATRICS AND ALLERGY LTD.

New/Updated Patient Information

Today's date: _____

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

Permanent address: _____
STREET **CITY, STATE, ZIP**

Home phone: _____ Cell phone: _____ Other: _____

E-mail address*: _____Patient's birth date_____

When an e-mail address is provided you will be "web-enabled". This will allow you to sign up for a "patient portal" to send and receive important information to/from the practice.

Preferred method of communication: ☐ Home number ☐ Cell number ☐ E-mail

Parents' names: Mother--Last name _____ First name _____

Father--Last name _____ First name_____

Do we have permission to contact this person/persons regarding matters concerning your care? ☐ Yes ☐ No

Name of insurance company: _____

Insurance subscriber's name
on insurance card: _____ Date of birth: _____

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

Primary race (check one):

☐ White	☐ Asian	☐ Other Pacific
☐ Hispanic	☐ Native American	☐ Other Race
☐ African American/Black	☐ Native Hawaiian	☐ Unreported/Refused

Preferred Language (check one): ☐ English ☐ Spanish ☐ Other: _____ Interpreter Needed? ☐Yes ☐No

<u>Preferred Pharmacy</u>

Name: _____ Address: _____

City:_____

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 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.***

HIPAA: I acknowledge that I have received the Bloomington Pediatrics and Allergy HIPAA privacy policy.

Signature: **_____** ***Date:*** **_____**

Revised 5/14