Colonial Medical Center

Eduardo Correa, MD - Natverlal Surati, MD

Patient Information Sheet

Today's Date:_____

Patient's Name:_____ **Date of Birth:** _____ **Age:** ____ **Sex:** ____

Address: _____ **City:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Preferred method of communication: _____ **Home Phone** _____ **Cell Phone** _____ **Email**

Mother's Name: _____ **Father's Name:**_____
Birthdate Birthdate

Primary Race: ___ White ___ Hispanic ___ African American
___ Asian ___ Native American ___ Pacific Islander
___ Other Race ___ Unreported/Refuse

Ethnicity: ___ Hispanic ___ Non-Hispanic ___ Refused to Report

Language: ___ English ___ Spanish ___ Other-Specify

Current Medications:

	Name:	Dose:	Frecuency:	Reason Taken:
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____

Allergies (Medication, Food, Environmental): _____

Preferred Pharmacy:
Name: _____ **Phone Number:** _____

Street Address:_____ **City:** _____ **State:** _____

Electronic Prescription: Our electronic medical record program asks you as the patient to allow us to access your prescription history in order for us to safely prescribe your medication. By signing this, you authorize us to do so.

Signature: _____ **Date:** _____

Inmunizations: Our electronic medical record program allows for your inmunization data to be sent directly to the I-CARE State of Illinois Registry. I-CARE allows your providers to obtain you inmunization history to ensure your safety. By signing this, you authorize us to submit this data.

Signature: _____ **Date:** _____