Please fax completed from back to RVCare at
secure fax: 815-921-4326

Date ____________________

Patient's Name (Last, First, MI):

____

Date of Birth: ____________________ **Age:** ______ **Sex: M F**

Race: [ ] Asian [ ] Black or African American [ ] Native American [ ] White / Caucasian

[ ] Other: ___________

State of Birth: _________________ **County of Birth:** __________________________

Mobile Phone Number: ________________ **Work Phone Number:** ________________________

E-Mail Address (W): _____________________**E-Mail Address (H)**: _________________________

Home Address: ____

Apt. # ____

City: ________________ State: _________________ Zip: ________________________

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Employer: ____________________________ Employment Status: [ ] Full time [ ] Part time [ ]

[ ] Retired [ ] Student [ ] Other: ____

Occupation: ____

Emergency Contact: ____

Relationship to Patient: ____

Address: ____

Phone number: ____

Primary Care Physician: ____

Travel out of the US in the last 30 days? Y N

If yes, where:____

Optional:

Religion: ____________________________Place of Worship: ______________________________

RVCare Health and Wellness Clinic
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Rockford, IL 61114
Ph (815) 921-4900
Fax (815) 921-4326