CURRENT PATIENT INFORMATION:

LAST NAME:_____ FIRST NAME:_____
MIDDLE NAME:_____
ADDRESS:_____
City State Zip
HOME PHONE:_____CELL PHONE:_____
WORK PHONE:_____PATIENT EMAIL:_____
SOCIAL SECURITY NO:_____ DATE OF BIRTH:_____
SEX: MALE / FEMALE

Required by government mandate (although you may refuse):

LANGUAGE: ☐ ENGLISH ☐ FRENCH ☐ SPANISH ☐ SOMALI ☐ OTHER_____

RACE: ☐ AMERICAN INDIAN ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ WHITE
☐ NATIVE HAWAIIAN/PACIFIC ISLANDER ☐ OTHER_____

ETHNICITY: ☐ HISPANIC ☐ NON-HISPANIC

MARTIAL STATUS: ☐ DIVORCED ☐ MARRIED ☐ PARTNER ☐ SINGLE ☐ WIDOWED

Other Information:

CONTACT PREFERENCE: ☐ HOME PHONE ☐ WORK PHONE ☐ CELL PHONE ☐ EMAIL ☐ PORTAL

PHARMACY INFORMATION: _____
Name Address Phone Number

BARRIERS TO COMMUNICATION: ☐ COGNITION ISSUES ☐ HEARING ☐ LEARING DISABILITY:
☐ LITERACY ☐ VISION

SEXUAL ORIENTATION:

☐ LESBIAN, GAY OR HOMOSEXUAL
☐ BISEXUAL
☐ SOMETHING ELSE
☐ STRAIGHT OR HETEROSEXUAL
☐ DON'T KNOW
☐ CHOSE NOT TO DISCLOSE

GENDER IDENTITY:

☐ MALE
☐ FEMALE
☐ TRANSGENDER FEMALE/ MALE TO FEMALE
☐ TRANSGENDER MALE/ FEMALE TO MALE
☐ OTHER
☐ CHOOSE NOT TO DISCLOSE

ARE YOU A VETERAN: ☐ YES ☐ NO

PROVIDER INFORMATION:
PRIMARY CARE DOCTOR:_____PATIENT REFERRED BY: _____

EMPLOYER INFORMATION:
EMPLOYER:_____
ADDRESS:_____
PHONE NUMBER:_____

ARE YOU CURRENTLY IN SCHOOL? ☐ YES ☐ NO
☐ FULL-TIME ☐ PART-TIME

HAVE YOU OR A MEMBER OF YOUR FAMILY WHOM YOU LIVE WITH EVER DONE AGRICULTURAL WORK AS YOU PRIMARY EMPLOYMENT? ☐ YES ☐ NO ☐ MIGRANT ☐ SEASONAL

GUARANTOR INFORMATION (to whom statements are sent):
NAME:_____
ADDRESS:_____
RELATIONSHIP TO PATIENT:_____
DATE OF BIRTH:_____ SOCIAL SECURITY NUMBER:_____
PHONE NUMBER:_____

EMERGENCY CONTACT INFORMATION:

NAME:_____ RELATIONSHIP_____
PHONE(HOME/CELL)_____

INCOME INFORMATION:
ANNUAL INCOME:_____
DO YOU WISH TO BE CONSIDERED FOR THE DISCOUNT SLIDING FEE SCHEDULE? ☐YES ☐NO
NUMBERS OF PERSONS SUPPORTED BY THIS INCOME? _____
WHAT IS YOUR CURRENT LIVING SITUATION?
☐STABLE HOUSING ☐HOMELESS SHELTER ☐DOUBLING UP ☐ STREET ☐TRANSITIONAL
☐OTHER:_____

INSURANCE INFORMATION:

Insurance Plan Name: _____
Group Number:_____
Member Identification Number: _____
Last Name:_____
First Name:_____
Date of Birth:_____
Employer Name:_____
Patient Relationship to policy holder:_____

(Secondary Insurance Information)

Insurance Plan Name:_____
Group Number:_____
Member Identification Number:_____
Last Name:_____
First Name:_____
Date of Birth:_____
Employer Name:_____
Patient Relationship to policy holder:_____

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I hereby acknowledge that I have received and read Eastern Iowa Health Center (EIHC) doing business as Eastern Iowa Dental Center's Notice of Privacy Practices and the Patient Responsibility form and understand its contents.

I certify that the above information is true and correct to my knowledge. My signature below indicates I accept financial responsibility for this account and for payments of services rendered to me and to my spouse and/or dependents.

I authorize EIHC DBA EIDC to release my insurance company any medical information necessary to file and process insurance claims. I authorize my insurance to assign benefits to EIHC DBA EIDC for dental services to me or my dependents. I certify that any information given by me for in applying for payment under any medical insurance program, including Medicare and Medicaid, is correct.

I have voluntarily presented myself to EIHC DBA EIDC for dental evaluation, diagnosis and/or treatment and I consent and authorize my provider(s) to provide and treatments, diagnostic procedures/tests, cultures or other dentally-accepted tests which may be necessary or advisable in their professional judgment. By signing this form, I do not waive my ability to refuse any recommended tests or treatment(s).

I understand and authorize EIHC DBA EIDC to request and use prescription medication history from other healthcare providers and /or third party pharmacy benefits payers for treatment purposes. EICH DBA EIDC also will enroll me in the ePrescribe program and send future prescriptions to my preferred pharmacy electronically when available.

I authorize EIHC DBA EIDC to contact me on the phone number listed above by text or phone call for appointment reminders and correspondence with my provider and their staff. I authorize EIHC DBA EIDC to contact the emergency contact listed above in the case of a dental emergency.

I certify that I have read and fully understand all the above statements and consent fully and voluntarily to its content. I have had a chance to ask questions and all my questions have been answered to my satisfaction. All above statements will apply to me and any member or my family.

To the best of my knowledge the above information is complete and accurate.

Signed_____**Date**_____