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| --- |
| **Please fill out all the fields. *Por favor complete el formulario.* Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  |
| 1. **Is this appointment for a New Patient? □ Yes □ No.**

***¿La cita es para un paciente nuevo?*  □ Si □ No.** 1. **If you have been here before, when was your last appointment?**
2. **Who gave you information about us?**

***¿Quién le dio información sobre nosotros?******□ WIC □ Emergency Room (ER) □ Other Dental Office □ OBGYN □ PCP □Behavioral Health*** ***□ Jude House □MCHIP □Maternal Child Health □ Dept of Disabilities □Dept. of Social Serv □School □AERS □Other\_\_\_\_\_\_\_\_\_\_\_******4.* Females ONLY. ¿Are you pregnant? If your answer is YES, how many weeks?** ***¿Está embarazada? ¿Cuánto tiempo tiene de embarazo?*** |

|  |  |
| --- | --- |
| **First Name:*****Nombre:*** | **Last Name:*****Apellido:*** |
| **DOB:** ***Fecha de Nacimiento:*** | **Age:*****Edad:*** | **SS#:** |
| **Address/*Direccion****:***City/*Ciudad:*****State/ Estado:****Zip Code/*Codigo Postal:*** | **Phone Number:*****# de Telefono:* □ Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **□ Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **□ Other**  |
| **Email:** |
| **Insurance:** **Yes (Si) □ No □*****Tiene Seguro:***  |
| **Medicaid *□*** | **Medicare *□*** | **Dual Medicaid/Medicare *□*** | **Private insurance*****Seguro Privado:*** |
| **Legal Guardian and/or Caregiver:*****Guardian legal:*** |

**MCO:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **UHC □** | **Medstar □** | **Priority Partners □** | **Amerigroup □** | **Aetna □** | **Care First □** | **Kaiser □** | **Other/ Unknown □** |

|  |  |
| --- | --- |
| **Gender** | **Race and/or Ethnicity (check all that apply):** |
| **Male □** | **Female □** | **Other □** | **White □ Black/African American □ Asian □ Native America/Alaska □****Pacific Islander/Hawaiian □ Hispanic/Latino □ Other/Unknown □** |

 **Marital Status:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Married □** | **Single □** | **Divorced □** | **Separated □** | **Widowed □** | **Other □** |
| **# of Dependents under the age of 18:** |

|  |
| --- |
| **For Office use ONLY: Appt Date: Time: Dr. Gray □ Dr. Cornwall □**  |