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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:** | | | | | |

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