

East Central Oklahoma Family Health Center, Inc.

**109 S Main
Wetumka, OK
74883**

**1102 W Main
Henryetta, OK
74437**

**217 S 5th
Henryetta, OK
74437**

**121 N Mekusukey
Wewoka, OK 74884**

Patient Information

Name: _____ Birthdate: _____ Age: _____

Sex: M F SSN: - - Home Phone Number: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Cell Phone Carrier: _____ Marital Status: S M D

PT Employer: _____ Address: _____

Employer Phone: _____ Position: _____

Spouse's Name: _____ Spouse Employer: _____

Address: _____ Phone: _____

PT Employment Status:

Employed Not Employed Self Retired Active Duty Veteran

Student Status: Full Time Part Time Not a Student

Race: (circle one) Black/African American American Indian/Alaska Native Native Hawaiian White
Other Pacific Islanders Asian More than One Race

Ethnicity: (circle one) Hispanic/Latino/Spanish Non-Hispanic/Latino Decline to Report

Please indicate the category for your annual household income (for statistical purposes only): (circle one)

\$0 - \$11,490 \$11,491 – \$22,980 \$22,981 – \$45,960 \$45,961 – \$68,940
\$68,941 and Above I choose not to answer

Pharmacy Name: _____

Person Responsible For Bill (If Other Than Patient)

Name	Birthdate	Parent/Guardian SSN	
Address	City	State	Zip
Employer	Business Phone	Position	

Insurance Coverage

Company	Policy Holder	Holder's Birthdate	Holder's SSN	Policy ID #	Group #	Employer
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1. _____
2. _____

Emergency Contact

Nearest Relation (Not Living In Household)

Name	Relationship
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Phone: _____

Second Contact	Relationship
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Phone: _____

Authorizations Treatment Release: I authorize my physician to provide the patient reasonable and proper medical care by today's standards.

Benefits To Physician: I hereby authorize payments to the ECOFHC for medical benefits. I also understand that I am responsible for any of my bill not covered by insurance.

Release of information: I hereby authorize release of information for insurance claim purposes Photostat of the above is valid as the original

I understand all of the above and hereby state that the information is correct to my knowledge. My signature indicates that I have read that a above and grant the request of authorizations.

SIGNED _____ DATE: _____