

ECO Family Health Center, Inc.

109 S Main
Wetumka, OK 74883

104 East Shurden Industrial Blvd.
Henryetta, OK 74437

207 W. 1st Street
Wewoka, OK 74884

1102 W. Main,
Henryetta, OK 74437

Patient Information

Name: _____ Birthdate: _____ Age: _____

Sex at Birth: Male Female SSN: _____ - _____ - _____

Home Phone Number: _____ Email: _____

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

Cell Phone: _____ Preferred Contact Phone # (circle one): HOME CELL WORK

Marital Status: Single Married Divorced

Employer: _____ Address: _____

Employer Phone: _____ Position: _____

Living Status: Not Homeless Homeless Homeless Shelter Transitional Doubling Up Street
 Permanent Supportive Housing

Employment Status:

Employed Not Employed Self Retired Active Duty Veteran

Student Status: Full Time Part Time Not a Student

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

Ethnicity: Hispanic/Latino/Spanish Non-Hispanic/Latino Decline to Report

Gender Identity: Male Female Transgender Male (Female-to-Male) Transgender Female (Male-to-Female) Other Choose not to Disclose

Sexual Orientation: Lesbian/Gay Straight Bisexual Something Else Don't know Choose not to Disclose

Pharmacy Name:

2nd Pharmacy Name:

Legal Guardian/Person Responsible for Bill (If Other Than Patient)

Name _____ Birthdate _____ Parent/Guardian SSN _____
Address _____ City _____ State _____ Zip _____
Phone# _____

Insurance Coverage (PLEASE PROVIDE CARD, IF AVAILABLE)

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

Emergency Contact

Name _____ Home Phone: _____ Cell Phone: _____
Relation: _____ Address: _____ City _____ State _____ Zip _____

Preferred Appointment Confirmation Method

Phone/Voicemail Text Message E-Mail

Authorizations Treatment Release: I authorize my physician to provide the patient reasonable and proper medical care by today's standards. This includes in-person and telehealth visits.

Benefits to Physician: I hereby authorize payments to the ECO Family Health Center 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. Photo copy of the above is valid as the original.

ECO Family Health Center participates in electronic health information exchange (HIE). Electronic HIE allows your healthcare team to share your electronic health records quickly and securely with each other for better patient care. If you want to opt out of your electronic record being shared with members of your health care team, let the front desk know and they can help you with the appropriate form.

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 above and grant the request of authorizations.

SIGNED _____ DATE: _____

ECO Family Health Center

Patient Portal Set-Up

Please provide us with your email address so that we may set you up with access to the patient portal system.

The patient portal system is designed to assist in giving you the best care possible by giving you anytime access to your health care information from any Internet-enabled device.

In the portal, you will have access to:

- View your health record
- View lab results
- View test results
- Request and manage appointments
- Exchange secure messages with your healthcare team

Patient Name: _____

Date of Birth: _____

E-Mail Address: _____

Mailing Zip Code: _____

If declining to provide e-mail address, please list reasoning: _____

After turning in this completed form, your login information will be sent to the e-mail provided.