

# ECO Family Health Center, Inc.

109 S Main  
Wetumka, OK 74883

104 East Shurden Industrial Blvd.  
Henryetta, OK 74437

121 N Mekusukey  
Wewoka, OK 74884

1102 W. Main,  
Henryetta, OK 74437

## Patient Information

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Sex at Birth:  Male  Female SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Marital Status:  Single  Married  Divorced

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_ Position: \_\_\_\_\_

### 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

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

\$0-\$11,490  \$11,491-\$22,980  \$22,981-\$45,960  \$45,961-\$68,940  \$68,941 and Above

**Pharmacy Name:**

\_\_\_\_\_

**2nd Pharmacy Name:**

\_\_\_\_\_

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

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Parent/Guardian SSN \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_ Position \_\_\_\_\_

**Insurance Coverage (PLEASE PROVIDE CARD, IF AVAILABLE)**

Company \_\_\_\_\_ Policy Holder \_\_\_\_\_ Holder's Birthdate \_\_\_\_\_ Holder's SSN \_\_\_\_\_ Policy ID # \_\_\_\_\_ Group # \_\_\_\_\_ Employer \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

**Emergency Contact**

**Nearest Relation (Not Living in Household)**

Name \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**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 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:** \_\_\_\_\_

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