



# Welcome to Doctors Care!

## Patient Application/Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Home Address: \_\_\_\_\_  
*Street Address City State Zip Code County*

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

How would you like to be reminded about your appointment? Check one:  Voicemail  Text  Both

Patient's Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Check one:  Single  Married

Name of Parent(s) or Guardian (if patient is a minor): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
*Name Phone Relationship*

*It is the policy of Doctors Care to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family/household size and annual income. Doctors Care is a nonprofit organization that depends on grant funding in order to provide services to you. Some of our grants require that we report the following information to them. We do not report this information to the IRS, Colorado Medicaid, or other state agencies.*

How many family members live in your home? \_\_\_\_\_

What is your estimated annual family income? \_\_\_\_\_

Email Address: \_\_\_\_\_ OK to email? Check one:  Yes  No

Ethnicity? Check one:  Caucasian  African American  Asian  Latino  American Indian  Native Hawaiian  
 Pacific Islander  Alaskan Native  Other:  Prefer not to respond

What is your preferred language? Check one:  English  Spanish  Other: \_\_\_\_\_

Have you had a dental cleaning in the past 6 months? Check one:  Yes  No

Do you have a dental home? Check one:  Yes  No If yes, where? \_\_\_\_\_

How did you find us? Check one:  Neighbor/Friend  Current Patient  Doctor Referral  Hospital  Sign

Medicaid/CHP+ Provider Web Site  School (explain): \_\_\_\_\_

Internet/Web Site (explain): \_\_\_\_\_  Advertising (explain): \_\_\_\_\_

Do you have Medicaid? Check one:  Yes  No

Do you have CHP+ Insurance? Check one:  Yes  No

Do you have insurance other than Medicaid or CHP+? Check one:  Yes  No If yes, name: \_\_\_\_\_

Do you live in a female head of household? Check one:  Yes  No

Pharmacy: \_\_\_\_\_  
**(We e-prescribe - no paper!)** *Name Address or Cross Streets*