HealthNet OF ROCK COUNTY

United Way Blackhawk Region Funded Partner

Today's Date:_____

Full Legal Name: _____

Birthday: _____ Age: _____Email: _____

Home Address: _____WI Zip Code: _____ City: _____

If you live in Beloit, do you live in the City of Beloit? Yes ☐ No ☐

Mobile Phone: _____ Home Phone: _____

Who would you like us to contact in case of an emergency?

Name	Relationship (i.e. mother)	Phone Number

If patient is a minor, please include the legal guardian's information as well.

Legal Guardian's Name: _____ Phone: _____

Guardian's Birthdate: _____ Address:_____

Relationship (i.e. mother, grandfather): _____

Ethnicity/Language/Smoking Status

Primary Language: _____ Preferred gender identity: _____

Ethnicity:
Hispanic or Latino/a ☐ Not Hispanic/Not-Latino/a ☐

Self-reported Race:

White ☐ Black/African American☐ Asian ☐ Native American or Pacific Islander ☐
American Indian/Alaska Native ☐ Multiple Races ☐ Other ☐

Household & Family Characteristics

What is the total estimated annual income for your household this year? _____

Place of Birth (State/Country): _____ Household size: _____
U.S. Citizen Yes ☐ No ☐ # of individuals age 17 or under _____
Legal Permanent Resident Yes ☐ No ☐ # of individuals age 18 or over _____

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Please check any of the boxes below that apply.

Patient is single ☐ Patient is a veteran or lives with a veteran ☐ Patient is homeless ☐

Patient has a disability or lives with someone who has a disability ☐

A female is the head of the patient's household ☐

Patient is part of a single-parent household ☐

Patient lives with an elderly (62+) person ☐

Please select your insurance provider: Uninsure ☐ Medicare Part A ☐ ForwardHealth/BadgerCare ☐ Veteran Affairs (VA) Health ☐

Insurance Number: _____

Dental History

How long since your last dental appointment? _____

Are you happy with the appearance of your teeth? Yes No

Please circle any of the below that apply.

Sensitive teeth	Bleeding gums	Painful teeth
Clicking in jaw joints	Pain in/near ears	Swelling/lump in mouth
Unusual taste/odor	Clenching/grinding teeth	

Smoking Status: Current Daily Smoker ☐ Current Intermittent Smoker ☐ Former Smoker ☐ Never Smoked ☐

Medical History

If you are currently seeing a primary care physician, please fill out the box below.

Clinic Name:_____ Clinic Phone #: _____

Physician's Name: _____

Are you currently taking any medication(s)? Yes ☐ No ☐

If yes, please list all medications:_____

_____

_____

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Do you chew tobacco? Yes ☐ No ☐
Are you allergic to latex? Yes ☐ No ☐
Do you have any other allergies? Yes ☐ No ☐

If yes, please list all your allergies: _____

_____

_____

Are you currently pregnant? Yes ☐ No ☐
If yes, how many weeks pregnant are you? _____

Please circle if you have a history of any of the following:

Arthritis	Diabetes	Glaucoma	HIV Positive	Heartburn
Artificial Joint	MRSA	Drug use/abuse	Kidney disease	Eating disorder
Radiation therapy	Tuberculosis (TB)	Rheumatic fever	Heart disease	Asthma
Seasonal allergies	Fainting spells	Bleeding problems	Heart murmur	Epilepsy
Mental illness	Hepatitis A/B/C	Mitral Valve Prolapse	Reaction to anesthetic	Seizures
Thyroid problems	Cirrhosis of liver	Gastric reflux	High/low blood pressure	

Other: _____

_____

_____

I attest that the above information is correct to the best of my knowledge:

Patient/Guardian Signature: _____ Date: _____