PATIENT INTAKE FORM

PATIENT DATA

PATIENT FIRST: _____ **M**: _____ **LAST**: ____ _____

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

Home Phone: _____ **Work Phone:** _____ ext: _____ **Other/Cell Phone**: _____

Date of Birth: _____ **Social Security #**: _____ **Sex:** ☐ **Female** ☐ **Male**

Email: _____ **Marital Status**: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

IF PATIENT IS UNDER 18 YEARS OLD:

Father: _____ **Date of Birth:**_____

Address:_____ **Phone #:** _____

Mother: _____ **Date of Birth:** _____

Address: _____ **Phone #:** _____

Legal Guardian **(if other than parents):** **Address:** **Phone #:**

EMERGENCY

EMERGENCY CONTACT: **Name:** _____ **Relationship:** _____

Address: _____ **City:** _____

State/Zip Code: _____ **Phone:** _____

****If patient is under 18 years old, proceed to Insurance Section. ****

EMPLOYMENT/RACE

ARE YOU A VETERAN? ☐ **Yes** ☐ **No** **ETHNICITY:** ☐ **Hispanic** ☐ **Non-Hispanic** ☐ **Decline to provide**

Race: ☐ **White** ☐ **Black/African American** ☐ **Asian** ☐ **Native Hawaiian/Other Pacific Islander** ☐ **Native American/Native Alaskan**

EMPLOYMENT STATUS: ☐ **Full-Time** ☐ **Part-Time** ☐ **Disabled** ☐ **Retired** ☐ **Unemployed**

Employer Name: _____ **Employer Phone Number:** _____

NOTE: Coos County Family Health Services, as a Federally Qualified Health Center, we are required by Federal Law to collect the following information for statistical purposes only. This is reported annually on a total patient basis. Individual patient information is NOT reported or disclosed. The collection of this information also assists CCFHS in applying for additional grant funds to support and expand its services. Thank you for your cooperation.

Number of household members: _____

Estimate of total household income (yearly):

☐ **$ 0.00 - $15,000** ☐ **$30,001 - $45,000** ☐ **$60,001 - $75,000**

☐ **$15,001 - $30,000** ☐ **$45,001 - $60,000** ☐ **$75,001 - over**

INSURANCE INFORMATION

☐ **PRIMARY INSURANCE COMPANY NAME:** _____ _____

Policy Holder Name: _____ **Policy ID#:** _____

☐ **SECONDARY INSURANCE COMPANY NAME:** _____

Policy Holder Name: _____ **Policy ID#:** _____

☐ **I HAVE NO INSURANCE** *Coos County Family Health Services offers a Discount Program to our patients to ensure that income or lack of insurance is not a barrier to care. Patients who are not covered by public or private insurance or have limited means to cover their co-insurance may apply for our sliding fee scale. Please inquire with Front Office Staff or the Billing Department.*

By signing below you are stating that the information you have provided is true, and you authorize CCFHS to verify that information, and release it to referring/mutual providers of care. You are also agreeing to allow CCFHS to share demographic and income data with State, Federal and Private grantors as necessary. You also acknowledge that you are financially responsible for the full balance of your charges if you are a self-pay; for the balance of your charges after any discount has been applied; and for any deductibles, co-pays or any services that your insurance does not cover. Any information provided that is discovered to be false now, or in the future, could be considered fraud for which you could be held liable. **We are not a free clinic and failure to fulfill your financial responsibility to us or agree to a payment schedule may result in your financial discharge from our services.**

Patient Signature (or Responsible Party): _____ **Date:** _____

Office Use Only: Employee Signature: _____ Date: _____ (Revised 10/2013)