

CLIENT INFORMATION SHEET

Print Name _____ Birthdate _____ Age _____
Last First Middle Maiden

Address _____ Home # _____ Best time to call _____
Cell # _____

City _____ State _____ Zip Code _____ County _____ SS# _____ - _____ - _____

I work: Full time Part time I do NOT work Place of Work and/or School _____

Work Phone _____ Best time to call _____ E-mail address _____

Emergency Contact: _____ Phone # _____

I live with: Spouse/Partner Parents Others Alone How many people live in your home? _____

We must be able to contact you to give you test results. Please check **all** the ways we may contact you:

- Call home Call work Call Home as "Heidi" Call Cell Phone Mail at home Plain envelope E-mail
- Other

Because we receive federal funds, we must collect this information about you:

You may check more than one: White African American/Black American Indian/Alaskan Native

Asian Pacific Islander/Native Hawaiian Unknown

Please check one: Origin: Hispanic/Latino Non-Hispanic/Non-Latino Unknown

Are you covered by public health insurance such as Medicaid, Medicare, CHIP, TRICARE/CHAMPUS, CHAMPVA or Kids Connection? Yes No Unknown

Are you covered by private health insurance? Yes No Unknown

Does your insurance cover Family Planning? Yes No Unknown

I wish to apply for reduced fees and will give staff complete and honest information about my income.

I do NOT wish to apply for reduced fees. Bill my insurance. Bill Medicaid # _____

LIST ALL SOURCES OF FINANCIAL SUPPORT

(show all amounts before any deductions)

Source Of Income:	- Your employment (pay stubs)	Monthly Amount: _____
	- Spouse/partner or Parent employment	_____
	- Dependent Children (AFDC/ADC)	_____
	- Child Support and/or Alimony	_____
	- SSI, Unemployment compensation	_____
	- Social Security, pension, railroad retirement, insurance & annuity payments	_____
	- Dividends, interest, rental income, trust funds	_____
	- Other sources (tips, allowances, etc.)	_____

How many people including yourself, does this income support? _____

Cost for services is based on a sliding fee scale. You are responsible for any fees that there may be.

Patient Signature _____ Date _____

ASSURANCE OF CONFIDENTIALITY: This medical record is confidential and will not be released to anyone without your written consent except as may be required by law.

FOR OFFICE USE ONLY: Staff Initials/Date _____

VERIFIED TOTAL MONTHLY INCOME _____ INCOME CODE: A(1) B(2) C(3) D(4) E(5)

3rd party: Ins Medicaid EWM