Patient Name: Patient ID: Date of Birth: __ __/__ __/__ __ __ __

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Social Security Number
			__ __ __ - __ __ - __ __ __ __

Date of Birth	Sex Assigned at Birth	Transgender?	Marital Status
__ __/__ __/__ __ __ __	☐ Female ☐ Male	☐ Yes	☐ Single ☐ Married ☐ Divorced ☐ Widowed

Mailing Address	City	State	Zip

Physical Address (if different than mailing address)	City	State	Zip

Home Phone	Cell Phone	Work Phone

Employer Name	Preferred Email
	Secondary Email

Employment Status	Student?	College or technical school?
☐ Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ Self Employed ☐ Disabled	Grade: _____	☐ Full time ☐ Part time

RESPONSIBLE PARTY (person to be billed if other than patient)

Last Name	First Name	Date of Birth
		__ __/__ __/__ __ __ __

Mailing Address (if different than patient)	City	State	Zip

Primary Phone	Relationship to Patient

Does Patient Have Insurance? Insurance Company:	Member Number:	Group Number:

The following information can help us to obtain grants and funding. THANK YOU in advance for completing this.

Race
☐ White (including Latino/Hispanic) ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander

Ethnicity	Primary Language:	Will you need an interpreter?
☐ Hispanic/Latino ☐ Not Hispanic/Latino		

Housing Situation
☐ Own or rent ☐ Staying with friends/sharing home ☐ Public Housing ☐ Homeless Shelter ☐ Transitional ☐ Living on street

How many dependents live in your house that you could claim on taxes? _____# adults (include you) _____# children	Household Income (all forms of income and support) Monthly _____	Are you a veteran of US Armed Forces? ☐ Yes ☐ No

FOR OFFICE USE ONLY

Qualify For Sliding Fee Discount Program?
☐ 138% & below ☐ 139-200% ☐ 201-250% ☐ 251-300% ☐ 301%+ ☐ Unknown/ Hasn't reported income

Intake completed by: Date: Data entered by: Date: