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| 🞏 New Patient 🞏 Existing Patient | | Encounter Date\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  Medical Rec. No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Patient Information** | | | |
| **Full Name (last, first, middle)** | | | **Street Address/P.O. Box Apt/Unit #** |
| **Social Security #** | **Date of Birth** | | **City State Zip County** |
| **Home Phone**  🞏Send reminder calls/text | **Cell Phone**  🞏Send reminder calls/text | | **Email Address** |
| **Other Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  🞏Send Reminder Calls/ Text | **Work Phone**  🞏Send Reminder Calls/ Text | | **Ethnicity**  🞏 Hispanic/ Latino  🞏 Non-Hispanic/ Non-Latino |
| **Race *(Check all that apply)***  🞏 Alaskan Native 🞏 Black/African Decent 🞏 White/  🞏 American Indian 🞏 Native Hawaiian Caucasian  🞏 Asian 🞏 Pacific Islander | | | **Primary Language**  🞏 English 🞏 Spanish ­­­ 🞏 Sign language 🞏 Other:­­­­­­­­  **Interpreter Needed**  🞏 No 🞏Yes |
| **Marital Status**  🞏 Single 🞏 Domestic Partner 🞏 Married  🞏 Divorced 🞏 Legally Separated 🞏 Widowed | | | **Gender**  **🞏** Female **🞏** Transgender: Female to Male  **🞏** Male  **🞏** Transgender: Male to Female |
| **Sexual orientation**  🞏 Straight or heterosexual 🞏 Bisexual  🞏 Lesbian, gay, or homosexual 🞏 Don't know  🞏 Other 🞏 Choose not to Disclose | | | **Is patient currently a student?**  🞏 Full-time Student  🞏Part-time Student  **Is patient a Veteran?**  🞏 Yes  🞏 No |
| **Is patient employed? (Check any that apply)**  🞏 Full Time 🞏 Part Time 🞏 Permanent  🞏 Temporary  **Agricultural Work (farming, planting, harvesting, raising livestock)**  🞏 No, I do not primarily work in agriculture  🞏 Yes, My primary employment is in agriculture | | | **Employment Status**  🞏 Employed 🞏 Unemployed 🞏 Unemployed  🞏 Self-Employed 🞏 Retired due to disability  **Employer Information**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Current Living Situation**  🞏 Own/lease🞏 Living with others (no lease)  🞏Transitional housing 🞏 Permanent supportive housing  🞏 Hotel/Motel 🞏 Airport, train station or bus station  🞏 Shelter 🞏 Car  🞏 Outdoors: Street, bridge, tent, park, abandoned building, etc.  🞏 Currently not homeless, but was in past 12 months  🞏 Prefer not to disclose | | | **Emergency Contact**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Preferred language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Responsible Party / Guarantor** | | | | | |
| 🞏 Self **(Skip Below)** 🞏 Spouse/Partner 🞏 Other: Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Complete below if guarantor is other than **Self** | | | | | |
| Last Name First Name MI | | | Street Address City State Zip | | |
| Social Security # | Date of Birth | Home / Cell Phone | | Work Phone | Email Address |

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| **History Of Applying For Medicaid** |
| Do you have Medicaid 🞏 Yes 🞏 No If you do NOT have Medicaid, have you ever applied? 🞏 Yes 🞏 No 🞏 N/A |

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| **Medical Insurance Information** | **Dental Insurance Information** |
| Do you currently have any medical insurance? 🞏 Yes 🞏 No  Medical Insurance Name  **If card presented to front desk staff skip below**  Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #  Address  Phone No. | Do you currently have dental insurance? 🞏 Yes 🞏 No  Dental Insurance Name  **If card presented to front desk staff skip below**  Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #  Address  Phone No. |
| **Vision Insurance Information** | |
| Do you currently have any vision insurance? 🞏 Yes 🞏 No  Vision Insurance Name | **If card presented to front desk staff skip below**  Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #  Address  Phone No. |

🞏 Check this box only if you DECLINE applying for the **Sliding Fee Application** (discounted rates dependent on income)

PATIENT/PARENT SIGNATURE DATE

**Complete this page only if applying for discounted rates**

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| **Sliding Fee Discount Scale Application**  **Mercy Care is a Federally Qualified Health Center, as such we are required to collect certain data from our patients to determine costs of services provided. Complete the form below only if you want to be considered for discounted fees.**  **\*Must be able to provide documentation of current income and housing status\*** | | | |
| 🞏 New Patient 🞏 Existing Patient | | | |
| **Household Members**  (Includes only persons you are related to by birth , marriage, adoption, or a legally defined dependent relationship) | | **Household Income**  Type Of Income | **Amount** (Monthly) |
| **Name Age Relationship**  **1.**  **2.**  **3.**  **4.**  **5.**  **6.** | | Gross Monthly Income you receive from Employment or Unemployment |  |
| Gross Monthly Income of your Spouse (or other Adult Family Member) |  |
| Other Employment Income  (Interest &Dividends and all income from employment produced by all dependents) |  |
| Social Security Income No. 1 ( Including Disability Income) |  |
| Social Security Income No. 2 ( Includes Supplemental SSI income) |  |
| Alimony/Child Support |  |
| Pension (Veteran’s Benefit & Retirement) |  |
| **Total Number of Household Members:** |  | **Monthly Total:**  **Annual Total:** |  |
| **For Mercy Care Staff-**  **Reviewed Total Household Size:** |  | **For Mercy Care Staff-**  **Reviewed Total Household Income:** |  |

PATIENT/PARENT SIGNATURE DATE

**Note:**