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| 🞏 New Patient 🞏 Existing Patient | Encounter Date\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_Medical Rec. No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Patient (Child's) Information**  |
| **Last Name First Name 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 | **Other phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Send Reminder Calls/ Text | **Sex at Birth**🞏Female🞏Male  |
| **Email Address** | **Primary Language**🞏 English 🞏 Spanish ­­­ 🞏 Sign language🞏 Other:­­­­­­­­ |
| **Race *(Check all that apply)***🞏 Alaskan Native 🞏 Black/African Decent 🞏 White/🞏 American Indian 🞏 Native Hawaiian Caucasian 🞏 Asian 🞏 Pacific Islander  | **Ethnicity**🞏 Hispanic/ Latino🞏 Non-Hispanic/ Non-Latino | **Interpreter Needed**🞏 No 🞏Yes |
| **Is patient employed? (Check any that apply)**🞏 Full Time 🞏 Part Time 🞏 Permanent 🞏 Temporary | **Is patient currently a student?**🞏 Full-time Student 🞏Part-time Student |
| **Parent/Guardian Information** |
| **Primary Parent Marital Status**🞏 Single 🞏 Domestic Partner 🞏 Married 🞏 Divorced 🞏 Legally Separated 🞏 Widowed | **Living Situation of Primary Parent/Guardian**🞏 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 |
| **Parent/Guardian/ Responsible for Payment (Guarantor)** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Second Parent/Guardian/Emergency Contact (Optional)**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Parent/Guardian Employment Status**🞏 Employed 🞏 Unemployed 🞏 Unemployed🞏 Self-Employed 🞏 Retired due to disability**Employer Information**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Second Parent/Guardian Employment Status (Optional)**🞏 Employed 🞏 Unemployed 🞏 Unemployed🞏 Self-Employed 🞏 Retired due to disability**Employer Information**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **History Of Applying For Medicaid**  |
| Does your child have Medicaid 🞏 Yes 🞏 No If your child does 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 🞏 NoMedical 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 below 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 the patient is 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:**