PATIENT INFORMATION FORM

Today's Date _____

Last Name _____ First _____ M.I. _____ Birthdate _____ Sex _____ Age _____

Social Security Number _____ Race: ☐ Black ☐ White ☐ Hispanic ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other _____

Address _____ Mother's Maiden Name _____

City _____ State _____ Zip _____ Name of Spouse or Parent/Guardian:

Residing County _____ _____

Telephone Numbers:

Home (_____) _____ In case of emergency, please contact

Work (_____) _____ _____

Other (_____) _____ Telephone #: (_____) _____

Employer's Name and Address: _____

Occupation: _____

Household Total Gross Monthly Income $ _____

_____

_____

_____

Insurance Information: *Please Provide Proof*

MEDICAID # _____

MEDICARE # _____

Insurance Company Name _____

Policy # _____

Anyone in household pregnant? ☐ Yes ☐ No

Do you have transportation problems? ☐ Yes ☐ No

Anyone in household under 21 with a serious or disabling condition? ☐ Yes ☐ No

Please give street address or simple directions to your home: _____

_____

List all members in your household: *(List Head of Household first.)*

NAME	RELATIONSHIP TO HEAD OF HOUSEHOLD	SOC. SECURITY NO.	SEX	BIRTHDATE
	Head of Household			

Please initial your response to the following:

Can we call you at the number listed above?____Yes _____No

If no, is there another number we can call?

Can we send mail to the address listed above?____Yes ____No

If no, is there another address where we can send your mail? _____

DO NOT WRITE BELOW THIS LINE

For Office Use Only:

REFERRED TO:

☐ Medicaid ☐ WIC
☐ JCIHCP ☐ CHSCN ☐ Norplant
☐ NCIHCP ☐ UTMB ☐ MQMB/QMB
☐ FP ☐ SSI ☐ Gulf Coast
☐ CH ☐ BCCS
☐ COPC ☐ Food Stamps
☐ Title X ☐ Other_____

ALREADY ELIGIBLE:

☐ Medicaid (SSI) ☐ WIC
☐ JCIHCP ☐ CHSCN
☐ NCIHCP ☐ UTMB
☐ Medicare ☐ COPC
☐ MQMB/QMB ☐ Income Too High
☐ Refused Referral ☐ Refused to be Screened
☐ Other_____

Screened By	Date
Pay Group	

Rev. 3/00