PATIENT INFORMATION AND INCOME VERIFICATION FORM

*******<u>**P L E A S E   P R I N T**</u> ******

TODAY'S DATE: _______________

GUARDIAN'S OR PARENT'S NAME:____
(if applicable) **Last** **First**

PATIENT'S NAME: ____
Last **First** **Middle/Maiden**

A **ADDRESS:** _______________________________________ **COUNTY:**_________

T **CITY:**_______________________ **STATE:**_______________ **ZIP CODE:** ___________

I **HOME PHONE:** _______________**WORK PHONE:** _______________**CELL PHONE:** ________________

E **EMAIL ADDRESS:**______________________________ **OK TO SEND MAIL TO HOME: Yes:**_____ **No:**____

N **SOCIAL SECURITY NUMBER (Patient):**_______________________ **DATE OF BIRTH:** ______________

T **Male:** ___ **Female:** ___ **Married:** ___ **Never Married:** ___ **Divorced:** ___ **Widowed:** ___ **Separated:** ___
YEARS OF EDUCATION:____ **PRIMARY LANGUAGE: English:**____ **Spanish:**____ **Other:**__________

RACE: White Non-Hispanic: ____ **White Hispanic:** ____ **Black Non-Hispanic:** ____ **Black Hispanic:** ____
Asian:____ **Native American:** ____ **Hawaiian/Pacific Islander:** ____ **Multi-Racial:** ____

MEDICAID: Yes ___ **No** ____ **PEACHCARE: Yes** ____ **No** _____
MEDICARE: Yes ___ **No** ____ **PRIVATE INSURANCE: Yes**_____ **No** ____

NOTE: CERTAIN PROGRAMS OR SERVICES OFFER DISCOUNTED FEES TO LOWER INCOME PATIENTS. TO APPLY<u>, PLEASE PROVIDE THE FOLLOWING INFORMATION BELOW.</u> IF THIS INFORMATION IS NOT PROVIDED & VERIFIED, A FULL FEE FOR SERVICES WILL BE CHARGED.

*****NUMBER OF FAMILY MEMBERS IN HOUSEHOLD YOU ARE RESPONSIBLE FOR**: __________
*****INCOME SOURCES** (Need one of the following to verify income **for each working household member**):

- <u>**Earned**</u>:

___ 2 most recent payroll stubs or pension checks/stub Weekly $____________ OR Monthly$ ___________
___ Most current tax return (W-2 or 1040) Weekly $____________ OR Monthly$ ___________
___ On-Going financial records (for self insured) Weekly $ ____________OR Monthly$ ___________
___ Unemployment Compensation verification Weekly $____________ OR Monthly$ ___________
___ Unemployment notice to verify status: Date of Unemployment: _____________________

- <u>**Unearned:**</u> Do you have any other sources of income? Yes: __ No: __ If yes: List source and how often Received (e.g., monthly, annual, one-time, etc.)

TOTAL INCOME: $______________ per <u>Week</u> or <u>Month</u> or <u>Year</u> (Circle the one that is appropriate).

<u>CONSENT & STATEMENT OF ACCURACY OF INFORMATION PROVIDED</u>

I consent for services to be performed by the Cobb and Douglas Boards of Health. I understand I am responsible for full payment of Boards of Health scheduled fees in cash (no checks are accepted) or by credit or debit cards at the time of service unless I qualify for special discounted fees certain programs offer which are based upon my and/or my household's income and number of dependents which I have provided truthfully and accurately above. If any charges are owed to the Boards of Health, they must be paid within 30 days from the date of service.

Signature: ____ Date: ______________________
Patient, Parent or Guardian's Signature

No Status Change Per: _______________________________________ Date: ______________________
Patient, Parent or Guardian's Signature