Health Care Application
All Information is required and Confidential

PATIENT INFORMATION

Patient Name: Last: _____ First: _____ MI: _____
Preferred:_____ Date of Birth:_____/_____/_____
Mailing Address:_____ Apt#:_____
City: _____ State: _____ Zip:_____

Sex: qMale qFemale qTransgender qUnknown **Marital Status:** q Single q Married q Divorced q Widowed

Social Security:_____ /_____/_____ **Race:** (Please check one): qWhite/Caucasian qBlack/African American

qAmerican Indian/Alaskan Native qAsian qNat Hawaiian / Pacific Islander

Home phone:_____ Work Phone:_____ Cell Phone:_____
May we leave voicemail messages on your home/Cell phones qYes qNo qHome only qCell only

**** THIS SECTION MUST BE COMPLETED FOR RESPONSIBLE PARTY OR IF PATIENT IS A MINOR *****

Last Name:_____ First:_____ Date of Birth:_____ SS#:_____
Mailing Address:_____ Apt#:_____ City:_____ State: _____ Zip:_____
Home Phone: _____ Work Phone: _____
Cell Phone:_____ Relationship to the Child:_____
Emergency contact:_____ Phone #(if different from above)_____

Relationship:_____
Email Address:_____ **Ethnicity:** qHispanic/Latino qNot Hispanic/Latino

Preferred Pharmacy:_____ Primary Language:_____

Employed: q Yes q No

Preferred Communication method:qPhone- Home qPhone-Cell qPhone-Work qEmail qPatient portal qMail

Living Arrangement: qLives in own home qSignificant other's home qRelative's home qFoster home qGroup/institution qHomeless/Shelter (If homeless, date you became homeless _____)

Veteran Status: q Veteran q Non-Veteran **Agricultural work status:** q Non-Agricultural q Employed Year- round q Seasonal q Migrant q Retired Farmworker

INSURANCE: THIS INCLUDES MEDICAID,MEDICARE AND ALL COMMERCIAL INSURANCES
Uninsured: q Yes q No Do you wish to apply for a discount q Yes q No (you must complete sliding fee discount application)

Primary Medical Insurance:_____
Plan Policy Holder:_____
Policy Number:_____

_____ _____
Patient or Patient Representative Signature If Representative, relationship

_____
Date

** Patient Representative must be a parent or guardian, if patient is a minor. If representative is not a parent, you must provide legal documentation proving authorization to have minor treated. **

CA Initials:_____ New:_____ Updated:_____ Date:_____

HEART OF FLORIDA DISCOUNT APPLICATION

Household Information: Please list **ONLY yourself** first, then **spouse and any minor children** (Under 18, if you have legal custody).

Name	Relationship to Patient	Social Security Number	Date of Birth

Employment and Income (If none, please write none/If Self Employed please circle Self and state name of business)

Employer Name /Self _____ Phone_____
Salary/Wage/Tips: _____ per (circle one) Month Biweekly Week Hour (if hourly, how many hrs./week_____)

Employer Name /Self _____ Phone_____
Salary/Wage/Tips: _____ per (circle one) Month Biweekly Week Hour (if hourly, how many hrs./week_____)

Employer Name /Self _____ Phone_____
Salary/Wage/Tips: _____ per (circle one) Month Biweekly Week Hour (if hourly, how many hrs./week_____)

Employer Name /Self _____ Phone_____
Salary/Wage/Tips: _____ per (circle one) Month Biweekly Week Hour (if hourly, how many hrs./week_____)

YOU MUST PROVIDE PROOF OF YOUR FINANCIAL STATUS ANNUALLY TO MAINTAIN ELIGIBILITY
Other Income: If you, your spouse, or minor children receive income listed below, enter the dollar amount

Food stamps	Workers Comp	Insurance payments
Disability	Unemployment	Boarder/rental income
Social Security (SSI/SSA)	Veteran's Compensation	Pension/Retirement
Alimony/Child support	Retirement	Contributions
Other (Explain)		

Does anyone else in your household work or receive income? (If so, please list and explain)

_____

_____

INTAKE ACKNOWLEDGEMENTS

I have answered all questions truthfully, completely and to the best of my ability; including dollar amounts. I understand that failure to do so may result in denial of eligibility to receive services. I agree that Heart of Florida Health Center may verify this information through the use of a third party vendor. The facility, its employees, officers and practitioners are hereby released from any legal responsibility or liability for disclosures as indicated and authorized herein.

Signature:_____ **Date:**_____

FOR OFFICE USE ONLY

CA Initials:_____ New:_____ Updated:_____ Date:_____

Approved:_____ Previous Application Date:_____ Annual household income:$_____