HEART OF FLORIDA HEALTH CENTER

Health Care Application
All Information is required and Confidential

PATIENT INFORMATION

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

Sex: ☐Male ☐Female ☐Transgender **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐Unknown ☐

Social Security: _____ /_____/_____ **Race:** (Please check one): ☐White/Caucasian ☐Black/African American ☐American Indian/Alaskan Native ☐Asian ☐Nat Hawaiian / Pacific Islander **Ethnicity:** ☐Hispanic/Latino ☐Not Hispanic/Latino

Home phone: _____ Work Phone: _____ Cell Phone: _____
May we leave voicemail messages on your home/Cell phones ☐Yes ☐No ☐Home only ☐Cell 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: _____

Preferred Pharmacy: _____ Primary Language: _____

Employed: ☐ Yes ☐ No **Household Income**: _____

Preferred Communication method: ☐Phone- Home ☐Phone-Cell ☐Phone-Work ☐Email ☐Patient portal ☐Mail

Living Arrangement: ☐Lives in own home ☐Significant other's home ☐Relative's home ☐Foster home ☐Group/institution ☐Homeless/Shelter (If homeless, date you became homeless _____)

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

INSURANCE: THIS INCLUDES MEDICAID,MEDICARE AND ALL COMMERCIAL INSURANCES
Uninsured: ☐ Yes ☐ No Do you wish to apply for a discount ☐ Yes ☐ No (If yes, 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: _____