coös county Family Health

PATIENT INTAKE FORM

PATIENT DATA

Patient First: _____ **Middle:** _____ **Last:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ ext: _____ **Other/Cell Phone:** _____

Date of Birth: _____ **Social Security #:** _____ **Sex:** ☐Female ☐Male

Email: **Marital Status:** ☐Single ☐Married ☐Divorced ☐Widowed

IF PATIENT IS UNDER 18 YEARS OLD:

Father: _____ **Date of Birth:** _____

Address: _____ **Phone #:** _____

Mother: _____ **Date of Birth:** _____

Address: _____ **Phone #:** _____

Legal Guardian (if other than parents): _____ **Address:** _____ **Phone #:** _____

EMERGENCY

EMERGENCY CONTACT: _____ **Relationship:** _____

Address: _____ **City:** _____

State/Zip Code: _____ **Phone:** _____

EMPLOYMENT/RACE

NOTE: Coos County Family Health Services, as a Federally Qualified Health Center, is required by Federal Law to collect the following information for statistical purposes only. This is reported annually on a total patient basis. Individual patient information is NOT reported or disclosed. The collection of this information also assists CCFHS in applying for additional grant funds to support and expand its services.Thank you for your cooperation.

Are You a Veteran? ☐ Yes ☐No **Are You Agricultural?** ☐Yes ☐No

Are You Homeless? ☐ Yes ☐No **If "*Yes*" Do You Live In A:** ☐ Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other

ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Decline to provide

RACE: ☐White ☐Black/African American ☐Asian ☐Native Hawaiian/Other Pacific Islander ☐Native American/Native Alaskan ☐Decline to provide/Not Reported

SEXUAL ORIENTATION: ☐ Lesbian or gay ☐Straight ☐Bisexual ☐Something else ☐Don't know ☐Choose not to disclose

GENDER IDENTITY: ☐Male ☐Female ☐Other ☐Choose not to disclose ☐Transgender Male/Female-to-Male ☐Transgender Female/Male-to-Female

EMPLOYMENT STATUS: ☐Full-Time ☐Part-Time ☐Disabled ☐Retired ☐Unemployed ☐ Child ☐Student

Employer Name: _____ **Employer Phone Number:** _____

Number of household members: _____

Estimate of total household income (yearly): ☐ $ 0.00 - $15,000 ☐ $30,001 - $45,000 ☐ $60,001 - $75,000 ☐ $15,001 - $30,000 ☐ $45,001 - $60,000 ☐ $75,001 - over

«PatientFirst» «PatientMiddle» «PatientLast» DOB: «PatientDOB»

☐ PRIMARY INSURANCE COMPANY NAME: _____

Policy Holder Name: _____ Policy ID#: _____

☐ SECONDARY INSURANCE COMPANY NAME: _____

Policy Holder Name: _____ Policy ID#: _____

☐ I HAVE NO INSURANCE *Coos County Family Health Services offers a Discount Program to our patients to ensure that income or lack of insurance is not a barrier to care. Patients who are not covered by public or private insurance or have limited means to cover their co-insurance may apply for our sliding fee scale. Please inquire with Front Office Staff or the Billing Department.*

Coos County Family Health Services Sliding Fee Schedule as of March 1, 2020

FAMILY SIZE	INCOME	A - 0-100% Medical $10 Fee Dental $25 Fee		B - 80% DISCOUNT 101-133% Medical $20 Fee Dental $30 Fee		C - 60% DISCOUNT 134-168%		D - 40% DISCOUNT 169-200%		E - 20% DISCOUNT* 201-250%	
1	Annual	$0	$12,880	$12,881	$17,130	$17,131	$21,638	$21,639	$25,760	$25,761	$32,200
	Monthly	$0	$1,073	$1,074	$1,428	$1,429	$1,803	$1,804	$2,147	$2,148	$2,683
	Weekly	$0	$248	$249	$329	$330	$416	$417	$495	$496	$619
2	Annual	$0	$17,420	$17,421	$23,169	$23,170	$29,266	$29,267	$34,840	$34,841	$43,550
	Monthly	$0	$1,452	$1,453	$1,931	$1,932	$2,439	$2,440	$2,903	$2,904	$3,629
	Weekly	$0	$335	$336	$446	$447	$563	$564	$670	$671	$838
3	Annual	$0	$21,960	$21,961	$29,207	$29,208	$36,893	$36,894	$43,920	$43,921	$54,900
	Monthly	$0	$1,830	$1,831	$2,434	$2,435	$3,074	$3,075	$3,660	$3,661	$4,575
	Weekly	$0	$422	$423	$562	$563	$709	$710	$845	$846	$1,056
4	Annual	$0	$26,500	$26,501	$35,245	$35,246	$44,520	$44,521	$53,000	$53,001	$66,250
	Monthly	$0	$2,208	$2,209	$2,937	$2,938	$3,710	$3,711	$4,417	$4,418	$5,521
	Weekly	$0	$510	$511	$678	$679	$856	$857	$1,019	$1,020	$1,274
5	Annual	$0	$31,040	$31,041	$41,283	$41,284	$52,147	$52,148	$62,080	$62,081	$77,600
	Monthly	$0	$2,587	$2,588	$3,440	$3,441	$4,346	$4,347	$5,173	$5,174	$6,467
	Weekly	$0	$597	$598	$794	$795	$1,003	$1,004	$1,194	$1,195	$1,492
6	Annual	$0	$35,580	$35,581	$47,321	$47,322	$59,774	$59,775	$71,160	$71,161	$88,950
	Monthly	$0	$2,965	$2,966	$3,943	$3,944	$4,981	$4,982	$5,930	$5,931	$7,413
	Weekly	$0	$684	$685	$910	$911	$1,150	$1,151	$1,368	$1,369	$1,711
*Add the following Amounts for Each Additional Family Member (over 6):	Annual		$4,540		$6,038		$7,627		$9,080		$11,350
	Monthly		$378		$503		$636		$757		$946
	Weekly		$87		$116		$147		$175		$218

By signing below you are stating the information you have provided is true, and you authorize CCFHS to verify that information, and release it to referring/mutual providers of care. You acknowledge that you are financially responsible for the full balance of your charges if you are a self-pay; for the balance of your charges after any discount has been applied; and for any deductibles, co-pays or any services that your insurance does not cover. Failure to fulfill your financial responsibility to us or agree to a payment schedule may result in your financial discharge from our services.

☐ I do not wish to apply for the sliding fee scale or do not qualify for the sliding fee scale.

☐ I decline to provide financial information.

☐ I would like to apply for the sliding fee scale by completing an Application for Financial Assistance (must be completed within 30 days of appointment)

Patient Signature (or Responsible Party): _____ Date: 6/28/2021

For Office Use Only:
Employee Signature: _____ Date: _____

Revised 07/2015, 05/2016, 02/2017, 6/2018, 2/2019, 3/2020