coös county Family Health

PATIENT INTAKE FORM

PATIENT DATA

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

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

Physical Address, if different than above: _____ **County:** _____

Home Phone: _____ **Work:** _____ **Mobile:** _____

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

Email: _____ **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Child ☐ Student

Education Level:

☐ None ☐ High School ☐ Associates Degree
☐ Bachelors College Degree ☐ Masters College Degree
☐ Doctorate Degree ☐ No Formal Education

Citizenship:

☐ Immigrant ☐ Naturalized Citizen ☐ Other ☐ Refugee
☐ Permanent Resident/Alien ☐ Student Visa
☐ US Citizen by Birth ☐ US Citizen 1st Generation

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 Contact

EMERGENCY CONTACT: _____ **Relationship:** _____

Address: _____ **City:** _____

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

Patient Information

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 (Migrant Farmworker)? ☐ Yes ☐ No

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

EMPLOYMENT STATUS: ☐ **Full-Time** ☐ **Part-Time** ☐ **Disabled** ☐ **Retired** ☐ **Unemployed**

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

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**

☐ **I decline to provide financial information.**

Number of household members: _____

Health Insurance Information

☐ 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.*

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.

Patient Signature (or Responsible Party): _____ Date: _____

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

Coös County Family Health Services Sliding Fee Schedule as of March 1, 2022

FAMILY SIZE	INCOME	A 0-100% Medical $10 Fee Dental $25 Fee		B 101-133% Medical $20 Fee Dental $35 Fee		C 134-168% Medical $30 Fee Dental $45 Fee		D 169-200% Medical $40 Fee Dental $55 Fee		E 201-250% 20% Discount* Family Planning	
1	Annual	$0	$13,590	$13,591	$18,075	$18,076	$22,831	$22,832	$27,180	$27,181	$33,975
	Monthly	$0	$1,133	$1,134	$1,506	$1,507	$1,903	$1,904	$2,265	$2,266	$2,831
	Weekly	$0	$261	$262	$348	$349	$439	$440	$523	$524	$653
2	Annual	$0	$18,310	$18,311	$24,352	$24,353	$30,761	$30,762	$36,620	$36,621	$45,775
	Monthly	$0	$1,526	$1,527	$2,029	$2,030	$2,563	$2,564	$3,052	$3,053	$3,815
	Weekly	$0	$352	$353	$468	$469	$592	$593	$704	$705	$880
3	Annual	$0	$23,030	$23,031	$30,630	$30,631	$38,690	$38,691	$46,060	$46,061	$57,575
	Monthly	$0	$1,919	$1,920	$2,552	$2,553	$3,224	$3,225	$3,838	$3,839	$4,798
	Weekly	$0	$443	$444	$589	$590	$744	$745	$886	$887	$1,107
4	Annual	$0	$27,750	$27,751	$36,908	$36,909	$46,620	$46,621	$55,500	$55,501	$69,375
	Monthly	$0	$2,313	$2,314	$3,076	$3,077	$3,885	$3,886	$4,625	$4,626	$5,781
	Weekly	$0	$534	$535	$710	$711	$897	$898	$1,067	$1,068	$1,334
5	Annual	$0	$32,470	$32,471	$43,185	$43,186	$54,550	$54,551	$64,940	$64,941	$81,175
	Monthly	$0	$2,706	$2,707	$3,599	$3,600	$4,546	$4,547	$5,412	$5,413	$6,765
	Weekly	$0	$624	$625	$830	$831	$1,049	$1,050	$1,249	$1,250	$1,561
6	Annual	$0	$37,190	$37,191	$49,463	$49,464	$62,479	$62,480	$74,380	$74,381	$92,975
	Monthly	$0	$3,099	$3,100	$4,122	$4,123	$5,207	$5,208	$6,198	$6,199	$7,748
	Weekly	$0	$715	$716	$951	$952	$1,202	$1,203	$1,430	$1,431	$1,788
*Add the following Amounts for Each Additional Family Member (over 6):	Annual		$4,720		$6,278		$7,930		$9,440		$11,800
	Monthly		$393		$523		$661		$787		$983
	Weekly		$91		$121		$152		$182		$227

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

☐ I would like to apply for the sliding fee scale. To apply, please request a Sliding Fee Application when returning this form, which must be completed within 30 days of appointment.

Patient Signature (or Responsible Party): _____ Date: _____

For Office Use Only:

☐ Handed Patient Application

☐ Mailed Application to Patient

Employee Signature: _____ Date: _____