coös county Family Health

PATIENT INTAKE FORM

PATIENT DATA

PATIENT FIRST: _____ **M**: _____ **LAST**: _____

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

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

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:**_____
(Parent 1)
Address:_____ **Phone #:** _____

Mother: _____ **Date of Birth:** _____
(Parent 2)
Address:_____ **Phone #:** _____

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

EMERGENCY

EMERGENCY CONTACT: **Name:** _____ **Relationship:** _____

Address: _____ **City:** _____

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

EMPLOYMENT / RACE

NOTE: Coos County Family Health Services, as a Federally Qualified Health Center, we are 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**

HAVE YOU OR A FAMILY MEMBER EVER SERVED IN THE MILITARY? ☐ **Yes** ☐ **No**

ETHNICITY: ☐ **Hispanic** ☐ **Non-Hispanic** ☐ **Decline to provide** ☐ **Not Reported**

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** ☐**Declined to provide** ☐ **Not Reported** ☐**Other** ☐**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**

☐ 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, 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

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: _____

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

Revised 07/2015, 05/2016, 02/2017, 6/2018, 2/2019, 02/2021, 02/2022