PATIENT ACCOUNT NUMBER _____ **Translator Needed: YES/ NO**

The Athens Neighborhood Health Center

PATIENT INFORMATION

Last Name: _____ First Name: _____

Date of Birth: (m) _____(d)_____(y)_____ Sex: Male____ Female____Transgender___

Race: _____ Marital Status (M/S): _____ Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home No. (_____) _____ **Work No.** (_____) _____ **Cell No.** (_____) _____

Are you a resident of the Athens Housing Authority? _____yes _____no

Have you been treated at the Center before? If yes, When? _____

Are you a Veteran of the United States Armed Services? _____yes _____no

Who to Contact in Case of Emergency (not living at the same address)

Last Name: _____ First Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home No. (_____) _____ Work No. (_____) _____ Cell No. (_____) _____

Parent/Guardian Information (If other than patient)

Last Name: _____ First Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home No. (_____) _____ Work No. (_____) _____ Cell No. (_____) _____

Patient/Parents Email ADDRESS:_____

Pharmacy of Choice: Athens Neighborhood Health Pharmacy (or) _____

IF PATIENT IS A MINOR: I give my permission for the Athens Neighborhood Health Center to examine and treat the patient.

Parent/Guardian's Signature: _____ Date: _____

I authorize payment of medical benefits to Athens Neighborhood Health Center and its physicians for service delivered at the Center. I also authorize release of any records for treatment or process the necessary claims.

Patient/Guardian's Signature: _____ Date: _____

ANHC – FINANCIAL STATUS & INSURANCE COVERAGE INFORMATION

Medicaid/Medicare Patients

Medicaid Number #_____

Medicare Number #_____

*******PLEASE PRESENT YOUR MEDICAID/MEDICARE CARD*******

Responsible Party Signature: _____ Date: _____

Non-Medicaid/Medicare and Uninsured Patients should completed the following Information

_____ I have Medical Insurance Coverage with: _____

Identification or Group #: _____

Policy Holder Name:_____ Policy Holder Relationship:_____

*******PLEASE PRESENT YOUR INSURANCE CARD*******

_____ I do not have Medical Insurance Coverage and would like to be placed on the Center's Sliding Fee Schedule.

ALL PATIENTS ARE EXPECTED TO COMPLETE THE TABLE BELOW:

Family Size	**Circle the income range in relation to your family size that best describes your household income**				
1	Below $14,759	$17,820	$20,790	$23,760	$23,761
2	Below $20,024	$24,030	$28,035	$32,040	$32,041
3	Below $25,199	$30,240	$35,280	$40,320	$40,321
4	Below $30,374	$36,450	$42,525	$48,600	$48,601
5	Below $35,549	$42,660	$49,770	$56,880	$56,881
6	Below $40,724	$48,870	$57,015	$65,160	$65,161
7	Below $45,911	$55,095	$64,278	$73,460	$73,461
8	Below $51,112	$61,335	$71,558	$81,780	$81,781

If you have **more than 8 people** living in your household, please complete table below.

How many people live in your household?	What is your family income?

Name of Family Member First-Middle-Last	Relationship to Applicant	Date of Birth

My signature certifies that the information above is true and accurately reflects my Financials status and Insurance Coverage.

Signature_____ Date_____

I authorize the release of my health information to the following:

_____ Relationship:_____

_____ Relationship:_____

Staff Use Only

Total Number of Family Members	

Income Range	**$**

Resident of Public Housing _____Yes _____No

Veteran _____Yes _____No