MR #:____________________

Patient Application

Name: ____
(*Last*) (*First*) (*Middle I.*)

Address: ____
(*City/State)* *(Zip)*

Mailing Address *(if different than above*): ____

County of Residence: ________________________ Date of Birth: ________________________

Home Phone Number: ________________________ Cell Phone Number: ____________________

Social Security Number: ________-_________-_________ Sex (*please circle*): **M** **F**

E-Mail Address: ____

I was referred by: ____

Please circle and fill-in your responses as indicated below:

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

Spouse's Name: ____

Total Number of people residing in your household: ____________________________________

Please list names with relation: ____

____

Gross Annual Income per Household: ____

Do you receive Food Stamps? Y N If yes, how much/month: $____________________

Employment Status: **Full-time** **Part-time** **Unemployed** **Retired**

Employer: ____

Occupation: ____

MR #:_______________________

Insert Information (please circle which type of insurance coverage you have):

Medicare **Medicaid** **High-Deductible** **No Insurance**

If High-Deductible, my deductible is: $____

If No Insurance, please indicate why? ____

Preferred Language: ____

Race: ____

Ethnicity: _____Hispanic/Latino _____Not Hispanic/Latino

Emergency Contact: ____

Phone Number: ____

I testify that all information documented above is true. I understand that failure to provide truthful information may result in declination or discontinuation of my services at Unfailing Love Clinic.

Signature: _______________________________ Date: _______________