Erie Family Health Center | Centro de Salud Erie
Trust. Heal. Care.

New Patient Information

Patient Information

Name (Last)_____ (First)_____ (MI) _____

Street Address_____ Apt. #:_____ City_____ State _____ Zip Code_____

Home Phone_____ Cell Phone _____

Date of Birth: _____/_____/_____ SS#_____
Month Day Year

Are you: ☐ Single ☐ Married/Partner ☐ Widow/Widower ☐ Divorced ☐ Separated

Family size: total number of people living in your house: _____ (dependent children, spouse/partner, parents or in-laws)

Sex: Female ☐ Male ☐ E-Mail Address: _____

Preferred Pharmacy: _____

Primary Language: ☐ English ☐ Spanish ☐ Polish Other _____

What method would be the best way to contact you? ☐ Home Phone # ☐ Cell Phone # ☐ E-mail

Erie will occasionally send text messages related to your care, including appointment reminders.

If you do NOT wish to receive text messages, please check here ☐

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Phone # _____

How did you hear about Erie Family Health Center? _____

Please select one of the following:

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other or Undetermined

Race: ☐ Asian
☐ Black or African American (Including Black or African American of Latino/Hispanic descent)
☐ American Indian/ Alaska Native (Including American Indians or Alaska Natives of Latino/Hispanic descent)
☐ White (Including Whites of Latino/Hispanic descent)
☐ Pacific Islander/Hawaiian Native
☐ Multicultural
☐ Undetermined
☐ Prefer not to answer

Insurance Information: ☐ All Kids/Medicaid ☐ Erie Discount ☐ Medicare ☐ Commercial Insurance ☐ Other

Please give us the following information:

Policy Holder:_____ Insurer:_____ Policy Number:_____

If you are divorced/separated, is your former spouse/partner financially responsible for medical care? ☐ YES ☐ NO

Parent/Legal Guardian Information

Name (Last)_____ (First)_____ (MI) _____

Date of Birth: _____/_____/_____ Sex: ☐ Female ☐ Male Social Security Number:_____

Month Day Year

Address: _____ City:_____ State: _____ Zip Code: _____

Home Phone #: (____) _____ Cell Phone #: (____) _____Work Phone #: (____) _____

E-mail Address: _____

Patient signature*: X_____ Date: _____

*By signing the above line, I attest that the information provided is truthful and accurate.

Parent/legal guardian*: X_____ Date: _____

All patients, including those with insurance may be eligible for Erie's Sliding Fee Scale Discount program. If you selected Erie Discount you must complete the section below: **Sliding Fee Scale Discount Program**

Sliding Fee Scale Discount Program

Do you have a job right now? ☐ YES ☐ NO Does your spouse/partner have a job right now? ☐ YES ☐ NO

Do any of the other family members who live with you have a job right now? ☐ YES ☐ NO

Household Members & Income (dependent children, spouse/partner, parents or in-laws)

Household Member Name	Relationship to Patient	Birth Date (MM/DD/YYYY)	Social Security Number	Monthly Income (Check-stubs)	Student? (Yes/No)	Seasonal Income
1				$		$
2				$		$
3				$		$
4				$		$
5				$		$
6				$		$
7				$		$
8				$		$

Proper proof of income documents must be provided for each household member.

Assets

Bank Accounts / Investments: Please list the current balance in each of the following. If you do not have any account listed below, please enter "N/A" in the space provided.

Checking account $ _____ Savings account $ _____

Certificate of Deposit$ $ _____ Stocks/Mutual Funds $ _____

Applicant must provide statements for each type of account claimed.

Household Income (Only complete if you can't provide Tax Return)

Complete this section **ONLY** if you can't provide or have not submitted your most current Tax Return for the previous year.

Social Security Income $_____ Disability income $_____

Unemployment compensation $_____ Alimony income $_____

Business income $_____ Rental & royalty income $_____

Dividend income $_____ Interest income $_____

Retirement or pension income $_____

Applicant must provide documents for each type of income above.

Certification

I promise that everything I have written on this form is true and right as far as I know. I understand that Erie Family Health Center may make sure that what I have said on this form is true, and I authorize Erie Family Health Center to contact third parties to make sure that the information is right. I understand that if I said anything in this application that is not true, I will not be able to get financial help, any financial help may be reversed, and I will have to pay back any charges.

Patient/Applicant Name: _____ Date: _____

Patient/Applicant Signature: _____ Date: _____

To be filled out by EFHC staff

Check box if verified and obtained

☐ Acceptable identification for each family member listed on SFS application

☐ All family members names and dates of birth listed on SFS application

☐ Acceptable income verification obtained

- ☐ Current Federal Tax Return
- ☐ Last 30 days paycheck stubs
- ☐ Company letter stating annual earnings
- ☐ Official letters/documents

_____ _____ _____

Signature of EFHC staff *Date* *Printed Name*

I-CARE

Information surrounding immunizations given will be submitted to I-CARE, the Illinois Comprehensive Automated Immunization Registry Exchange. The primary goal for I-CARE is to increase the immunization coverage level of Illinois' children. By giving your child consent to receive immunizations, you are also consenting transfer information to I-CARE.

Patient signature*: X_____ Date: _____

*By signing the above line, I attest that the information provided is truthful and accurate.

Parent/legal guardian*: X_____ Date: _____

*By signing the above line, I attest that the information provided is truthful and accurate..

To be completed by Dental Patients

Date of Last Dental Visit: _____

Have you ever had any of the following? Please check those that apply

- ☐ AIDS
- ☐ Allergies _____
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Head Injuries
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Radiation Treatment
- ☐ Respiratory Problems

Has the patient had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

Has the patient been admitted to a hospital or needed emergency care during the past two years ☐ Yes ☐ No

If yes, please explain: _____

Is the patient now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

Does the patient have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

Patient signature: X_____

*By signing the above line, I attest that the information provided is truthful and accurate.

Parent/legal guardian: X_____

*By signing the above line, I attest that the information provided is truthful and accurate.