For Office Use Only:	Circle One:	Intake or Renewal:	MCD	MCR	Private	Slide Fee	Patient #: _____

Today's Date:_____ HealthLinc YOUR COMMUNITY HEALTH CENTER® Date of Birth:_____

Patient Legal Name:		Social Security:
Patient Preferred Name:	US Resident: Y / N Refugee: Y / N Country of Origin:	
Address:		Telephone:
City: State: Zip code:		Township/County:
Email address:	Veteran: Y / N Discharged: Y / N Date of Discharge: / /	
Emergency Contact:	Relationship:	Telephone:

List all individuals living in household (list each separately, INCLUDING THE PATIENT):

Name	M/F	Age	Date of Birth	Relation	SSN

Gender Identity	
Male	
Female	
Transgender Male/ Female-to-Male	
Transgender Female/ Male-to-Female	
Other	
Declined to answer	

Marital Status	
Single	
Married	
Separated	
Divorced	
Widowed	

Monthly Household Income	
None	$
Wages-Gross	$
Disability	$
Unemployment	$
Social Security	$
Workman's Comp	$
Monthly Total	$
Annual Total	$

Sexual Orientation	
Straight	
Gay	
Lesbian	
Bisexual	
Other	
Unknown	
Declined to answer	

Employment	
Full Time	
Part Time	
Self-Employed	
Retired	
Seasonal Worker	
Migrant Worker	
Unemployed	

Annual Household Income	
$0-20,000	
20,001-50,000	
50,001-100,000	
100,001+	

Homeless	
Homeless Shelter	
Transitional	
Doubling Up	
Street	
Other	
Unknown	

Race	
Black/African-American	
Asian	
Native Hawaiian	
Other Pacific Islander	
American Indian/Alaskan National	
White	
More than one race	
Refused	

Insurance	
Patient Refused Intake	
Uninsured	
Medicare	
Medicaid	
Medicaid Pending	
HIP	
Private Insurance	

Ethnicity				
Are you Hispanic/Latino?	Yes		No	

Preferred Pharmacy
Address:

Primary Language	
English	
Spanish	
Other	
Do you need an interpreter?	

Preferred Communication Method					
Text		Email		Voice	

It is my responsibility to keep HealthLinc informed of any change in address, phone number, income, and/or health coverage.

I understand that the information which I submit is subject to verification by HealthLinc, federal and/or state enforcement agencies, and others as required. Under penalty of perjury and/or fraud, I affirm that the above information is true and correct.

_____ _____

Applicant (signature) ***Applicant*** (printed name)

(The section below is for Office Use Only)

Proof of Income Provided (circle one): Yes No Medical Slide Fee _____ Dental Slide Fee _____ Renewal Due _____ Entered _____ Date: _____ Scanned: _____

This health center receives HHS funding and has Federal Public Health Service (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals.