COMMUNITY DENTAL CLINIC

3428 Armour, Fort Smith AR 72904

Phone: 479-782-6021

Application must have all required documents and submitted in person for processing.

PLEASE READ

Check ☑	**To be a CDC patient you must be able to check all the boxes & meet income guidelines: If over income may still apply for service based on your income for reduced fees. *We cannot accept incomplete applications***
	You must live in Crawford or Sebastian County. **Include one Utility Bill (GAS, ELECTRIC or WATER) with YOUR physical Address. Letters from shelter are ACCEPTED.**
	Copy of **Picture ID for the patient and anyone in the home over 18**.
	Copy of **Social Security Cards for all individuals in the household.**
	I certify I do not have **Dental Insurance** or **Dental Covered Medicaid** located on **Intake page of application.**
	For anyone working: copies of **5** recent **check stubs (**this applies to anyone working in the home regardless if they're related or not). **No income complete zero-income statement and have notarized.**
Warning: **3 steps must be completed in this section.** **1.** ________ **2.** ________ **3.** ________	**1.** Everyone in the home including children must have a letter from the **Social Security Office.** Stating you DO or DO NOT Receive a benefit or that it is pending. (Security office located @ 6801 Dallas St.) **2**. If divorced or separated a letter from the Child Support Office for any children that you're the custodial parent must be included. (Child Support office is located @ 3132 Alma Blvd, Van Buren) **3.** 18 and over must have a Review Claim Transaction from the **UNEMPLOYMENT OFFICE**, even if you receive SSI, SSA, or SSD. (Unemployment office located @ 616 Garrison Ave #101 Fort Smith)

READ and SIGN THIS PAGE –

YOU MUST CALL TO CANCEL YOUR APPOINTMENT. IF YOU NO-CALL OR NO-SHOW.

YOU MAY NOT BE SEEN FOR UP TO ONE YEAR.

Clinics are by appointment only! We are NOT a WALK-IN CLINIC. Rude behavior or cursing the DENTIST or STAFF is not acceptable and YOU will be banned from the Dental Clinic.

- **We DO NOT provide cosmetic dentistry, orthodontics, sedation, or root canals. CROWNS AND FILLINGS ARE PROVIDED at reduced fees. CLEANINGS are provided January – April with limited space. FOR cleanings you may be referred to UAFS Hygiene School.**
- **Non- English-speaking patients should have a translator with them at all dental appointments.**
- **A pregnant patient must have a note from her doctor giving permission for an X-ray and treatment.**
- **If you have a serious medical condition that requires you to be under the care of a physician it may be necessary to provide a medical clearance before treatment. If you have had joint replacement or heart problems that require a Pre-med you will need to get that from your doctor before dental treatment. If you take blood thinners you must check with your doctor about how long you must be off blood thinners before & after dental work!**

- **We are unable to provide treatment in another facility, such as a nursing home or hospital. The patient must be able to come to the dental clinic, move to a dental chair for treatment, and answer the dentist's questions.**
- **We have a limited denture program. DENTURES ARE ONLY AVAILABLE WHEN WE HAVE FUNDING.**
- **Every person applying for dental treatment will need their own application.**
- **DO NOT BRING CHILDREN TO YOUR DENTAL Appointment.**

- **This is a DRUG FREE Establishment: Alcohol & drugs are not allowed at the Community Dental Clinic.**
- **Do not call the Dentist at home or at their regular office! If you call them at their regular office you will pay the rates they charge at their office. Calling the Dentist at home will cause you to be BANNED from the Community Dental Clinic.**
- **Make sure to take all daily medications as you normally would, except in the case that your doctor or dentist has given you specific instructions not to.**

- **NO pets are allowed in the building. DO NOT BRING YOUR PETS.**

- **NO SMOKING IN and OR on property of THE DENTAL CLINIC. IF YOUR NAME IS CALLED AND YOU ARE OUTSIDE SMOKING IN YOUR VEHICLE, YOUR DENTAL APPOINTMENT WILL BE RESCHEDULED.**

Patient Signature____________ Date: ____________

INTAKE/PATIENT PROFILE PLEASE PRINT

____

Patient Name: ____ **SS#**_____-____-_________

DATE OF BIRTH: _____/_____/_______ **AGE:** ______ **SEX: MALE:** _______ **FEMALE:** _______

ADDRESS: ________________________________ **CITY:** ___________________ **ZIP:** ____________

PHONE:(_____) __________________**Home or Cell EMAIL Address:** ________________

Race: African American: ___ **Asian:** ___ **Hispanic:** ___ **Native American:** ___ **White:** ______

Multi Race: ___ **Other:** ____ **Primary Language: ENGLISH:** ___ **SPANISH:** ___ **OTHER:** ____

TYPE OF HOUSEHOLD:

SINGLE: _____ **MARRIED:** ________ **SEPERATED:** ________**DIVORCED:** _________ **WIDOWED:** ___________

ARE YOU A: SINGLE PARENT_______ **2 PARENT HOUSEHOLD**______ **DIVORCED With CHILDREN**_______

HOMELESS: ________ **OTHER:** ____ **MULTI GENERATION:** _________

DO YOU OWN: ____ **RENT:** ____ **OR SHELTER/TREATMENT:** _____ **HOMELESS:** _____ **OTHER:** ______

ARE YOU A FARMER: YES: ____ **NO:** ______ **SEASONAL FARMER?** ______

TYPE OF INCOME:

EMPLOYED: _____ **UNEMPLOYED:** _____ **UNEMPLOYED HOW LONG:** ______ **BENEFIT:** ________

DO YOU RECEIVE: SSA ___ **SSI**_____ **SSD**_____ **Child Support**_____ **Pension**_____ **Other**________

INCOME amount: $________________ **WEEKLY:** _____ **BI WEEKLY:** ____ **MONTHLY:** ________

IF NO INCOME, ASK FOR ZERO INCOME CHECK LIST.

DO YOU RECEIVE: FOOD STAMPS: ____ **TEA:** ______ **HUD:** ______ **GENERAL ASSISTANCE:** ______

ARE YOU Disabled: YES or NO or PENDING

Are you a VETERAN: Yes or No VA Benefits Amount $_____________**?**

Dental Insurance: I certify that I do not have Dental Coverage:

Signature_____________________________ **Date:** _____________

Health Insurance: YES____ **NO**_____

TYPE OF INSURANCE: _________________________________

Education level:

NON-Grad: _____ **GRADUATE:** ______**GED:** _____ **12+ Post-Secondary** ______
2- or 4-years college ________

FAMILY or ADDITIONAL HOUSEHOLD INTAKE INFORMATION: IF NO ADDITIONAL HOUSEHOLD PLEASE SKIP. PLEASE MAKE SURE TO ANSWER ALL QUESTIONS FOR EACH PERSON, WE CAN NOT ACCEPT INCOMPLETE APPLICATIONS. MUST INCLUDE ID AND PROFF of INCOME FOR

Patient Health History

PLEASE PRINT

Patient Name____ Date of Birth__________________

	YES	NO		YES	NO
Are you in good health?			Have you had abnormal bleeding?		
Are you under a Doctor's care?			Problems when teeth pulled?		
Date of last physical exam:			Have you ever had a blood transfusion?		
Name of Primary Doctor: _________________________ Weight______________ Height________________			Have you had a recent weight loss without cause?		
Pharmacy Name: ___________________ Pharmacy #__________________________			Do you use tobacco products? If so, what type:		
NOTE: If you have heart problems, joint replacement, or are pregnant we will need a note from your doctor concerning treatment.			Have you used controlled substances? Chemical Dependency: Alcohol Dependency:		
Have you been hospitalized for a serious illness or operation?	**Yes**	**No**	Do you drink alcohol?		
Are you taking any medications?			Do you have a persistent cough or throat clearing not due to a known illness?		
If yes, what medications do you take: ____			**If you are female:**	YES	NO
			Are you pregnant?		
			Due Date:		
			Are you nursing?		
Do you take a blood thinner? If yes, which one?			**What is your dental need:**		

HEALTH INFORMATION & ALLERGIES

ALLERGY OR REACTION TO:	**YES**	**NO**	**HEALTH HISTORY continued**	YES	NO
Local anesthetics like Novocain			**Diabetes**		
Penicillin			Eating Disorder		
Sulfa Drugs			Enlarged Lymph glands		
Pain medications (**Lorcet, Lortab, codeine**)			Epilepsy or Seizures		
Aspirin			Gastric Bypass		
Tylenol/Ibuprofen			**Heart Trouble:** Heart Attack, Angina, Chest Pain		
Any metals (i.e. nickel, mercury, etc.)			Heart Surgery: **Pacemaker, Bypass, etc.**		

Health problems that you may have or medications that you may be taking could have an important effect on your dental care. Thank you for answering the following questions so that we may provide better dental care to you.

Patient **Health History CONTINUED**

PLEASE PRINT

Patient Name____

	YES	NO		YES	NO
Latex/Rubber			**Fainting**		
Other? Please List: medicines you are allergic to: ____ ____ ____ ____ ____			**Heart Defect or Heart Murmur**		
			Hepatitis		
			High Blood pressure		
			Hives or skin rash		
			Hypoglycemia (low blood sugar)		
	YES	NO	**Joint/Bone replacement or implant**		
Foods			Kidney Dialysis, Transplant, or Disease		
If yes, please list:			Nervous Disorders/Depression		
			Pancreatitis		
			PTSD		
HEALTH HISTORY	YES	NO	Rheumatic Heart Disease/Rheumatic Fever		
Acid Reflux			Scarlet Fever		
AIDS or HIV Infection			Shortness of Breath		
Anemia			Sinus Problems		
Arthritis			Stomach Problems		
Asthma or Breathing Problems			Stroke		
Autoimmune Disorder – (Lupus, Rheumatoid Arthritis)			Swelling of feet, ankles, hands		
Cancer -			Thyroid Problems		
Cortisone Treatment			Tuberculosis		
Do you require the use of corrective lenses			Tumors, radiation, chemotherapy		
DENTAL HEALTH	YES	NO			
Do your gums bleed when you brush or floss			Are any of your teeth currently causing you pain		
Do you grind your teeth			Are any of your teeth loose		
Do you currently have any dental implants, dentures, or partials			Do your teeth experience sensitivity to cold or hot temperatures		

Health problems that you may have or medications that you may be taking could have an important effect on your dental care. Thank you for answering the following questions so that we may provide better dental care to you.

CONSENT FOR EXTRACTION OF TEETH

Extraction of teeth is an irreversible process and, whether routine or difficult, is a surgical procedure. As in any surgery there are some risks. They include, but are not limited to the following:

- **Swelling and/or bruising and discomfort in the surgery area.**
- **Stretching of the corners of the mouth resulting in cracking or bruising.**
- **Possible infection requiring additional treatment.**
- **Dry socket-jaw pain beginning a few days after surgery, usually requiring additional care. It is more common from lower extractions, especially wisdom teeth removal.**
- **Possible damage to adjacent teeth, especially those with large fillings or caps.**
- **Numbness or altered sensation in the teeth, gums, lip, tongue and chin, due to the closeness of the tooth roots to the nerves (especially wisdom teeth) which can be bruised or damaged. Almost always, sensation returns to normal, but in rare cases, the loss may be permanent.**
- **Trismus-limited opening due to the inflammation swelling, most common after wisdom tooth removal. Sometimes it is a result of jaw joint discomfort (TMJ), especially when TMJ disorders already exist.**
- **Bleeding-significant bleeding is not common, but persistent oozing can be expected for several hours.**
- **Sharp ridges or bone splinters may form later at the edge of the socket. These usually require another surgery to smooth or remove.**
- **Incomplete removal of tooth fragments to avoid injury to vital structures such as nerves or sinus, sometimes small root tips may be left in place.**
- **Sinus involvement - the roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus or an opening may occur into the mouth, which may require additional care.**
- **Jaw fracture – although quite rare, it is possible in difficult or deeply impacted teeth.**
- **Allergic reactions to medications, although careful precautions are taken to obtain patient's history of allergies, certain dietary and medical factors may cause allergic reactions to medications used during tooth extraction.**

Although rare, resulting malocclusion (incorrect bite) requiring additional care. I understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following treatment, I agree to report them to the doctor or his designated agent as soon as possible. I realize that no guarantees or assurances have been given by anyone regarding treatment results that may be obtained. I also understand that if I have any questions regarding my treatment, I am to ask the doctor prior to signing this consent. I hereby acknowledge that I have read the foregoing, have discussed any questions or concerns I may have regarding my proposed treatment.

Teeth to be removed: AS NEEDED

Patient's Signature: ______________________________ Date: ______________

Patient HIPAA Privacy Acknowledgment & Authorization

Patient Name: ________________________________
Date of Birth: _____________ **Phone:** ________________
Address: ____

Notice of Privacy Practices

I acknowledge that I have received or been offered a copy of **Communtiy Dental Clinic Notice of Privacy Practices**, explaining how my protected health information (PHI) may be used and shared.

Initials: _______

Authorization for Dental Care Communication

I authorize **Community Dental Clinic** to use and disclose my health information for:

✔ Dental treatment (including exams, x-rays, extractions, dentures, and related care)
✔ Billing and payment
✔ Healthcare operations
✔ Appointment reminders (call, text, voicemail)

May we discuss your care with someone else?
☐ No
☐ Yes — Name & Relationship: _______________________________

Records Release (Optional)

I give permission for my dental records to be released to:

☐ Insurance provider
☐ Referring dentist/specialist
☐ Another provider at my request
☐ Other: _______________________________

Purpose: Continuing care, payment, or as requested by the patient.

Patient Rights

- I understand I may revoke this authorization in writing at any time.
- Signing this form is voluntary, and my treatment will not be denied if I refuse to sign.
- I may request a copy of this form.

Patient / Legal Guardian Signature: ___________________________

Printed Name: _______________________________

Relationship (if guardian): ________________

Date: _____________

DENTURE and DENTAL TREATMENT REQUEST

The Community Dental Clinic operates with dentist, dental assistants and dental hygienists who volunteer their time and services. Consequently, we schedule patients for treatment at the earliest possible date that those needed services are available. We ask for your understanding and patience as we try to book you for your next appointment.

Please answer the following questions so we'll be better able to serve you.

1. What type of treatment are you needing?

◯**Dental Exam and X-rays**
◯**Extractions**
◯**Fillings or cosmetic dentistry**
◯**Dentures**
◯**cleaning or deep scales (RPS)**

Are you currently Having Pain? ◯ **YES** ◯ **NO** ◯ **N/A (NO teeth)**

Do you believe that treatment you receive at the clinic will?

Improve your Health? ◯ **YES** ◯ **NO** ◯ **N/A**
Improve your Quality of Life? ◯ **YES** ◯ **NO** ◯ **N/A**
Help with Job Placement? ◯ **YES** ◯ **NO** ◯ **N/A**
Help with your self-esteem? ◯ **YES** ◯ **NO** ◯ **N/A**

Please describe how dental treatment and dentures can help you?

____

____

____

Signature: ____

DENTURE / PARTIAL PROGRAM CONTRACT

PLEASE READ AND INITIAL EACH LINE AND SIGN AFTER READING

Patient Name: ______________________________ Date: _________________________

1. **The partials/dentures are $750.00 for a complete set. Denture's for low income patients are available with Dentist approval only. Community Dental will provide a denture/partial for the patient at no charge when and only funding is available, and the patient meets all requirements. __________**
2. **The partials/dentures you receive from the Community Dental Clinic will last about 4-6 years with careful use & care by you the patient. You will need to consider how you will replace this partial/denture in the future. __________**
3. **You will receive one set of partials/dentures from the Community Dental Clinic. The clinic will not be responsible for lost, stolen, or negligence (example dog ate) you will be responsible for total replacement of your denture/partials. __________**
4. **Only the dentist will determine if the partial/denture is defective and therefore covered by the Community Dental Clinic. _________**
5. **Patient receiving partials will need to continue to have their remaining teeth cleaned every six months. The Community Dental Clinic will not provide cleaning every 6 months. You will need to have a plan in place for these cleanings. ___________**
6. **Going from natural teeth to a denture/partial is a big adjustment for any patient. The ability to chew food decreases about 90%. Taste of food and often speech may be altered at first.**

CDC will do everything in our power to help you adjust to your new dentures, however, the patient must realize that dentures are a satisfactory replacement for having no teeth at all, but they rarely function as well as natural teeth. __________

Many times, you will need a soft reline in the first 2 months of a denture after extraction, this soft liner is temporary and can last up to 3 months. Soft liners are not covered by Community Dental Clinic, and is a separate fee. _________

After 6 months you may require a HARD Reline as your gums will have continued to shrink causing a loose-fitting denture. A Hard reline is permanent, and will give your denture a tighter fit. Hard Relined are not covered by Community Dental Clinic, and is a separate fee. ______

Consent: I have read the information above and have had a chance to review and discuss my planned treatment. I understand that there is no warranty or guarantee as to any result and understand I can ask for a full recital of any and all possible risks concerning my care by asking.

Signature: ____ Date: ____________________

Agreement to Receive Electronic Communication

Patient Name:____Date of Birth:
____

(Initial below)

I DO AGREE ______

I DO NOT AGREE _______

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

My most preferred method of electronic communication: (Initial Below)

_____ Text Messaging

_____

Email

I would like to receive:

_________Appointment Reminders/Recall Visits

_________Information regarding insurance/billing

_________Requests for Patient Satisfaction online reviews

I can withdraw my consent to electronic communications at any time by calling:

Community Dental Clinic @ 479-782-6021 or Email Communitydental17@gmail.com

Patient Signature:____Date:
____

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Adult-Photo or Video Release Consent Form

Patient Name ______________________________
Date_________________________

I hereby give my permission to the Community Dental Clinic in Fort Smith, AR located at 3428 Armour to use my photograph or film of me. I hereby waive all rights to the photograph or film and give my permission for these images to be published or distributed publicly.

Including listed below

My Name and photo may be released to outside sources.

My Name and photo may be posted on social media.

My Name and photo may be used in advertisement.

I understand that my refusal to sign will exclude me from being approved for our denture program and dental services, and that I will be charged normal fees.

Please Print Your Name: _____________________________

Signature: __________________________________ Date: ______________________

Zero Income Statement

Please complete the Zero Income Statement below if you are not currently working and have no income or support. If you are married and your spouse is not working or receiving income, please have them complete the Zero Income Statement as well.

I, ____

Date of Birth: __________________,

Certify that I am not currently working and have no income. I do not receive disability, pension, employee pay checks, trust payments, cash, TEA, child support, VA benefits, SSI, SSD, SSA benefits or unemployment benefits.

Signature ____

Date: ______________

Printed Name____

Notary Acknowledgement

STATE OF ___________________________

COUNTY OF _________________________

On this _____ day ________________of, 20__________ before me ____________________________________ the undersigned notary public, Have personally appeared before me and proved to me through satisfactory evidence of identification, which was the Zero Income Statement and driver license to be the person whose name is signed on the above preceding document in my presence.

_______________________________________ Place Seal or Stamp Below

Notary Public

My commission expires: _________________

Letter of Support

If you receive support by someone, please have them complete the Letter of Support on your behalf. (example lives with a friend or family member, receives money for food, housing, utilities.)

I____ provide support for ___________________________ Date of Birth: __________

As indicated below.

Check only one of the boxes:

□ Lives with me at the address below and receives free room and board. □Does not contribute to bills. □ **Does contribute to bills**

□ Does not live with me, but I provide support for

Check all below that you provide.

□ Food □ Housing □ Utilities □Cash

______________________________ _________________________

Signature Relationship to Client

______________________________ _________________________________

Printed Name Address

______________________________ _______________________________

Date City, State and Zip Code

I _____________________________________ that the statement or group of statements is the truth. That the person named above provides the services to me.

State of Arkansas

County of _____________________ "I _______________________________, certify this a true and original document Letter of Support presented to me on this ____________________day of ______________,20_____________. Proved to me on the basis of satisfactory evidence to the person whose name(s) is/are subscribed above. In witness whereof, I here unto set my hand and official seal

____

Signature of Notary Public

My commission expires: ______________________

[Seal of Office]

PLEASE READ AND INITIAL EACH LINE AND SIGN AFTER READING

- ❖ **I understand that the health care professionals who are licensed under the laws of the State of Arkansas and who render medical services voluntarily and without compensation to any person at any free or low-cost medical clinic located in the State of Arkansas and registered by the State Board of Health, which accepts no insurance payments and provides medical services free of charge to persons unable to pay or provides medical services for a nominal fee, shall not be liable for any civil damages for any act or omission resulting from the rendering of such medical services, unless such an act or omission was the result of such licensee's gross negligence or willful misconduct.**

- ✓ **I understand it is my responsibility to carry out any instructions for follow-up care recommended by the dentist. I also understand that volunteer dentists provide the dental work, and services at the dental clinic are limited to availability of a dentist.** ☐

- ❖ **I give permission for my photographs to be used by the Community Dental Clinic staff by the media, publicity, grants, to be kept on file, and to be on display.** ☐

- ✓ **I hereby grant authority to the Community Dental Clinic and those in charge of my care to administer any treatment and to perform such operations as may be deemed necessary in the treatment of my dental needs.** ☐

- ❖ **The information on this application is true to the best of my knowledge and belief. I understand if this form is signed you are subject to penalties for perjury.** ☐

- ✓ **We have a limited denture program. DENTURES ARE ONLY AVAILABLE WHEN WE HAVE FUNDING & DENTISTS. Only the Dentist decides if you need dentures then the staff places your name on a waiting list.** ☐

- ❖ **By intimal here I certified I have no dental insurance.** ☐

This office complies with Equal Opportunity & Affirmative Action practices. Our services are without regard to race, color, national origin, religion, sex, disability, familial status, or age. Please sign and date to signify that you are aware the Privacy Policy is posted at the Community Dental Clinic.

Patient Signature____

Household member #2

Relationship to PATIENT: ______________ MALE____ or FEMALE ______ SOCIAL SECURITY: _________________________

Name: _______________________________________ DATE OF BIRTH: ____/____/______ AGE ________

SINGLE: ______ MARRIED: ________ SEPERATED: _________DIVORCED: __________ WIDOWED: ____________

Race: African American: ___ Asian: ___ Hispanic: ___ Native American: ___ White: _______

Multi Race: ___ Other: ____ Primary Language: ENGLISH: ___ SPANISH: ___ OTHER: ____

TYPE OF INCOME:

EMPLOYED: _____ UNEMPLOYED: _____UNEMPLOYED HOW LONG: _______ BENEFIT________________

DO YOU RECEIVE: SSA ____ SSI_____ SSD_____ VA_____PENSION_____ Child Support_______

INCOME amount: $__________________ WEEKLY: ____ BI WEEKLY: ___ MONTHLY: ___________

IF NO INCOME, ASK FOR ZERO INCOME CHECK LIST.

DO YOU RECEIVE FOOD STAMPS: ____ TEA: ______ HUD: ______ GENERAL ASSISTANCE? ______

Are YOU Veteran: __________________ ARE YOU Disabled: ________________________

DO YOU HAVE Health Insurance: YES____ NO_____ TYPE OF INSURANCE? ________________

Your Education level:

Education: GRADE 0-8: ___ 9-12: ___ GRADUATE: ____GED: ___ 12+ Some Post-Secondary ___

2- or 4-years college ___

Household member #3

Relationship to PATIENT: ______________ MALE____ or FEMALE___ SOCIAL SECURITY: ___________________

Name: _______________________________________ DATE OF BIRTH: ____/____/______ AGE ________

SINGLE: ______ MARRIED: ________ SEPERATED: _________DIVORCED: __________ WIDOWED: ____________

Race: African American: ___ Asian: ___ Hispanic: ___ Native American: ___ White: _______

Multi Race: ___ Other: ____ Primary Language: ENGLISH: ___ SPANISH: ___ OTHER: ____

TYPE OF INCOME:

EMPLOYED: _____ UNEMPLOYED: _____UNEMPLOYED HOW LONG: _____ BENEFIT_________

DO YOU RECEIVE: SSA ____ SSI_____ SSD_____ VA_____PENSION_____ Child Support_______

INCOME amount: $__________________ WEEKLY: ____ BI WEEKLY: ___ MONTHLY: ___________

IF NO INCOME, ASK FOR ZERO INCOME CHECK LIST.

DO YOU RECEIVE FOOD STAMPS: ____ TEA: ______ HUD: ______ GENERAL ASSISTANCE? ______

Are YOU a Veteran: __________________ ARE YOU Disabled? ________________________

DO YOU HAVE Health Insurance: YES____ NO_____ TYPE OF INSURANCE? ________________

Your Education level:

Education: GRADE 0-8: ___ 9-12: ___ GRADUATE: ____GED: ___ 12+ Some Post-Secondary ___

2- or 4-years college ___

Household member #4

Relationship to PATIENT: ______________ MALE____ or FEMALE ______ SOCIAL SECURITY: _________________________

Name: _______________________________________ DATE OF BIRTH: ____/____/______ AGE ________

SINGLE: ______ MARRIED: ________ SEPERATED: _________DIVORCED: __________ WIDOWED: ____________

Race: African American: ___ Asian: ___ Hispanic: ___ Native American: ___ White: _______

Multi Race: ___ Other: ____ Primary Language: ENGLISH: ___ SPANISH: ___ OTHER: ____

TYPE OF INCOME:

EMPLOYED: _____ UNEMPLOYED: _____UNEMPLOYED HOW LONG: _______ BENEFIT________________

DO YOU RECEIVE: SSA ____ SSI_____ SSD_____ VA_____PENSION_____ Child Support_______

INCOME amount: $__________________ WEEKLY: ____ BI WEEKLY: ___ MONTHLY: ____________

IF NO INCOME, ASK FOR ZERO INCOME CHECK LIST.

DO YOU RECEIVE FOOD STAMPS: ____ TEA: ______ HUD: ______ GENERAL ASSISTANCE? ______

Are YOU Veteran: __________________ ARE YOU Disabled: ________________________

DO YOU HAVE Health Insurance: YES____ NO_____ TYPE OF INSURANCE? ________________

Your Education level:

Education: GRADE 0-8: ___ 9-12: ___ GRADUATE: ____GED: ___ 12+ Some Post-Secondary ___

2- or 4-years college ___

Household member #5

Relationship to PATIENT: ______________ MALE____ or FEMALE___ SOCIAL SECURITY: ___________________

Name: _______________________________________ DATE OF BIRTH: ____/____/______ AGE ________

SINGLE: ______ MARRIED: ________ SEPERATED: _________DIVORCED: __________ WIDOWED: ____________

Race: African American: ___ Asian: ___ Hispanic: ___ Native American: ___ White: _______

Multi Race: ___ Other: ____ Primary Language: ENGLISH: ___ SPANISH: ___ OTHER: ____

TYPE OF INCOME:

EMPLOYED: _____ UNEMPLOYED: _____UNEMPLOYED HOW LONG: _____ BENEFIT_________

DO YOU RECEIVE: SSA ____ SSI_____ SSD_____ VA_____PENSION_____ Child Support_______

INCOME amount: $__________________ WEEKLY: ____ BI WEEKLY: ___ MONTHLY: ____________

IF NO INCOME, ASK FOR ZERO INCOME CHECK LIST.

DO YOU RECEIVE FOOD STAMPS: ____ TEA: ______ HUD: ______ GENERAL ASSISTANCE? ______

Are YOU a Veteran: __________________ ARE YOU Disabled? ________________________

DO YOU HAVE Health Insurance: YES____ NO_____ TYPE OF INSURANCE? ________________

Your Education level:

Education: GRADE 0-8: ___ 9-12: ___ GRADUATE: ____GED: ___ 12+ Some Post-Secondary ___

2- or 4-years college ___