complete HEALTH

Sliding Scale Discount Program Application

Name of Patient/Parent/Guardian		Phone	
Street	City	State	Zip
Social Security Number	Place of Employment		

Please list self, spouse, and dependents under age 18

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

OFFICE USE ONLY: Annual Household Income				
Source	**Self**	**Spouse**	**Other**	**Total**
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self-employment and dependents				
Rent, interest, dividend, and other income				
Total Income				

OFFICE USE ONLY: Verification Checklist	**Yes**	**No**
Identification/Address: Driver's license or other photo ID		
Income: Prior year tax return, most recent pay stubs or other		
Insurance: Insurance card(s)		

Patient / Patient Family has qualified for the Discount Program at Level: _____

Patient's visit co-pay will be _____ at each visit.

Patient Declined Discount Slide: _____
(Patient Initial)

I certify that the information shown above is correct and understand that 30 days' worth of income verification is required within 10 days of the appointment for approval.

_____ _____
Signature Date

Staff Initial: _____ Date: _____ Recertification Date:_____

MINOR

AUTHORIZATION FOR MEDICAL / DENTAL CARE OF A MINOR CHILD and EMERGENCY CONTACT

Patients Name: _____

Date of Birth: _____

SSN: _____

Please list those individuals, who in your absence may consent to care for your minor child. This will be good for one year of signature.

Name: _____ Relationship to patient: _____

Phone #: _____

Emergency _____ Yes _____ No, Appointment Info _____ Yes _____ No, Verbal Test Results _____ Yes _____No

Billing Info _____ Yes _____ No, Rx pick up _____ Yes _____ No

Name: _____ Relationship to patient: _____

Phone #: _____

Emergency _____ Yes _____ No, Appointment Info _____ Yes _____ No, Verbal Test Results _____ Yes _____No

Billing Info _____ Yes _____ No, Rx pick up _____ Yes _____ No

AND / OR

To be seen without Parent / Legal Guardian

I _____, give my consent for _____ to be seen without my presence and confirm that patient is at least 14 years old. This will be good for one year of signature.

Parent / Legal Guardian Signature: _____

Date: _____

ADULT

EMERGENCY CONTACT LIST

Name: _____ Relationship to patient: _____

Phone #: _____

Emergency _____ Yes _____ No, Appointment Info _____ Yes _____ No, Verbal Test Results _____ Yes _____No

Billing Info _____ Yes _____ No, Rx pick up _____ Yes _____ No

Name: _____ Relationship to patient: _____

Phone #: _____

Emergency _____ Yes _____ No, Appointment Info _____ Yes _____ No, Verbal Test Results _____ Yes _____No

Billing Info _____ Yes _____ No, Rx pick up _____ Yes _____ No