

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

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

Work Phone #: (____) _____ Other Phone #: (____) _____

May we leave medical information on your answering machine or voicemail?: _____ Yes _____ No

Email address: _____

Emergency Contact: Name: _____ Phone Number: _____

Relationship to You: _____ Can we leave a message with this person?: _____ Yes _____ No

Are you currently employed? (circle one):

Full Time Part Time Self Employed Retired Unemployed Student Disabled

If employed, where: _____ If unemployed, when were you last employed?: _____

Date of Birth: _____ Social Security Number: _____ - _____ - _____

Race/Ethnicity: _____ Circle One: Male Female

Are you married? (circle one): Married Single Legally Separated Divorced Widowed

Number of children: _____ Total number of people living in your household/place of residence: _____

Are you the head of the household (when filing taxes)? _____ Yes _____ No

Do you have any of the following?

Medicare Medicaid Private Insurance 100% Truman Discount

ER Visits or Hospitalization in the Last Year?

Date: _____ Hospital: _____

Reason for admission: _____

Do you smoke? _____ Yes _____ No _____ Quit Quit date: _____

Number of packs per day: _____ Years Smoking: _____

Do you chew tobacco? _____ Yes _____ No _____ Quit Quit date: _____

Do you drink alcohol? _____ Yes _____ No Drinks per week: _____ Quit date: _____

Have you used illegal drugs? _____ Yes _____ No _____ Quit Specify: _____

Do you exercise: _____ Yes _____ No Number of times per week: _____

Do you drink caffeine: _____ Yes _____ No Number of drinks per day: _____

The information you provide to the clinic is confidential and will be used only to calculate eligibility for medications and services.

- You will need to provide proof of your income and the income of everyone living in the same house as you.
- This includes (if applicable): most recent tax filing, W2, last 4 pay stubs, disability award letter, social security award letter, unemployment benefit letter, pension benefit letter, etc.
- Please fill out the table below, AND bring us income proof listed above each year to update your eligibility.

Name: _____ Today's Date: _____

The following table must be completed for everyone living in the same house as you.

Please list specific dollar amounts for each category:

MONTHLY INCOME	You	Household member (1)	Household member (2)	Household member (3)	Example
Salary and Wages					\$600
Child Support					
Social Security Retirement					
Social Security Disability					
SSI					
Retirement					
Pension Payments					
Unemployment					
Food Stamps					\$300
Rental Income					
Workman's Compensation					
Veteran's Benefit					
Investment Income					
Other:					

Household members with income (those you listed in the table above):

(1) Name _____ Relationship to you _____

(2) Name _____ Relationship to you _____

(3) Name _____ Relationship to you _____

Dependents living in the same house as you (those with no income):

(1) Name _____ Relationship to you _____

(2) Name _____ Relationship to you _____

(3) Name _____ Relationship to you _____

I agree that I have provided truthful information about my household finances.

Signature: _____