PATIENT MASTER FILE AND INCOME INFORMATION

Please Print:

(Patient)Last Name | First Name | Initial | Maiden Name

Address: Street # and Name | City | State | Zip | County

Social Security # | Date of Birth

Parent/ Guardian Name (must be filled out for patients under age 18) | Social Security # | Date of Birth

Home Phone _____ Work Phone _____ Pager or Cell Phone _____

Medicaid # _____
Medicare # _____
Peachcare # _____
Other _____

Race: American Indian/Alaskan Native _____
Asian _____
Black or African-American _____
Native Hawaiian/Other Pacific Islander _____
White _____

Ethnicity: Hispanic/Latino _____
Non-Hispanic/Latino _____

SEX: MALE or FEMALE MARRIED: YES or NO

Are you on Food Stamps? YES or NO

Have you any allergies? YES or NO - explain _____

Family Data: List everyone living in household including you. List all income, including child support and alimony. Also list any contributions or gifts from friends or family.

NAME	RACE	SEX	BIRTHDAY	RELATIONSHIP	INCOME BEFORE TAXES
					$
					$
					$
					$
					$
					$

Total number of people in household _____ Total monthly income before taxes $_____

I certify the above information to be correct _____ Date _____
Signature