Today's Date_________/______/____________

MM DD YR

PATIENT INFORMATION

Last Name ___________________________________First:______________________________MI:_______

Minor_____Single_____Married____Divorced_____Widowed_____Separated_____Common Law____

Sex: Female / Male Ethnicity: Hispanic / All Others Language___________________________

Race: Asian____ Hispanic____ Black / African American___ Native American___ White____ Other____

DOB____________________ SSN#_________________________ID_________________________________

Address_______________________________City_____________________State_____Zip______________

County________________________ Email____

Home Phone________________________Mobile________________________Other _________________

Insurance Company____Phone_______________________

Name of Insured_______________________________________DOB_________________ID_________

Relationship to Patient____

How did you hear about this health clinic? ____

In confirming your appointment, do you prefer? ___ CALL ___EMAIL

PATIENT'S FAMILY MEMBERS (Please list spouse, parents, children & other close relatives at home)

First Name, Middle Name, Last Name, Last Name of Mother (Maiden)	D.O.B	Relationship	Social Security #	Other Names Used

HOUSEHOLD INCOME

Total Monthly Income $ ___________________________Source of Income _______________

Mission Statement

Inner City Health Center is a Christ centered healthcare home for underserved individuals where consistent, high quality treatment is provided in an atmosphere of genuine respect. We express our love for Jesus Christ and our compassion for those in need through our deep concern for their physical, emotional and spiritual well-being.

RESPONSIBILITIES AND RELEASES

I understand that by receiving services from Inner City Providers for my family, or myself I am accepting responsibility for payment of charges. Co-Payment is due before treatment is rendered regardless of insurance coverage.
I authorize the release of any medical/dental or other information necessary to receive care at any other health care facility or receive payment for services rendered. I also authorize payment of insurance benefits to Inner City Health Center directly.

I authorize providers at Inner City Health Center to perform all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

By signing this document, I verify that the above information is correct and that I agree to notify Inner City Health Center when my financial status changes.

Signature____ Date_________________