



FAMILY PLANNING TITLE X
PATIENT INFORMATION AND INCOME DECLARATION

TODAY'S DATE: _____

GUARDIAN'S OR PARENT'S NAME: _____

PATIENT'S NAME: Last First Last Name at Birth

ADDRESS: _____

CITY: STATE: ZIP CODE: COUNTY:

HOME PHONE: WORK PHONE: CELL PHONE

HOW CAN WE CONTACT YOU? CHECK ALL THAT APPLY

- MAIL HOME CELL PHONE WORK PHONE

Date of Birth: Education (highest level complete): Do you need language assistance (interpreter)? Y or N

Sex: Male Female

Marital Status: Married Never Married Divorced Widowed

Race/Ethnicity: White Non-Hispanic White Hispanic Black Non-Hispanic Black Hispanic Native American Hawaiian/Pacific Islander Multi-Racial Asian

Medicaid: Yes: No: Peach Care: Yes: No: Medicare: Yes: No: *Private Insurance: Yes: No: (see attachment)

NOTE: Some programs offer reduced fees based on income. To apply for a reduced fee, please provide the following information:

Number of family members in household: _____

Total family income: \$ _____ per Week or Year (Circle one).

I do not wish to provide financial information to find out if I am eligible for a reduction in the basic fee.

Patient, Parent or Guardian's Signature Date

CONSENT & STATEMENT OF ACCURACY OF INFORMATION PROVIDED

I consent for services to be performed by the DeKalb County Board of Health. I understand I am responsible for full payment of the DeKalb County Board of Health scheduled fees in cash, check, credit or debit cards at the time of service unless I qualify for special discounted fees certain programs offer. Discounted fees are based on my and/or my household income and number of dependents, which I have provided truthfully and accurately above.

Signature: _____ Date: _____
Patient, Parent or Guardian's Signature

***Insurance Status**
(Check *one* box)

- All or some for Family Planning Services
- None for Family Planning Services
- Unknown for Family Planning Services
- Public (Medicaid)
- Uninsured
- Unknown