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

Rev.4/09

***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