FOR OFFICE STAFF ONLY

PATIENT NUMBER _____

DATE _____ CLERK _____

MEDICAID _____

SAGINAW COUNTY DEPARTMENT OF PUBLIC HEALTH

PERSONAL AND PREVENTIVE SERVICES
FAMILY PLANNING CLIENT ENROLLMENT FORM

FIRST NAME: _____ **MIDDLE:** _____ **LAST:** _____

MAIDEN NAME (IF DIFFERENT THAN ABOVE): _____

BIRTH DATE (MM/DD/YYYY): _____

SEX (CIRCLE ONE): FEMALE MALE

RACE (CHECK ALL THAT APPLY):

□ AMERICAN INDIAN/ALASKAN □ ASIAN □ AFRICAN AMERICAN
□ HAWAIIAN/PACIFIC ISLANDER □ WHITE

ETHNICITY (CHECK ONE ONLY):

□ HISPANIC □ NON-HISPANIC □ UNKNOWN

MARITAL STATUS:

□ NEVER MARRIED □ MARRIED □ DIVORCED □ SEPARATED □ WIDOWED

CONTACT INFORMATION

HOME ADDRESS

STREET: _____ **APT:** _____

CITY : _____ **STATE:** _____ **ZIP CODE:** _____

COUNTY OF RESIDENCE: _____ **TOWNSHIP:** _____

MAY WE SEND MAIL TO THE ABOVE ADDRESS? YES NO

IF NO, PLEASE PROVIDE AN ADDRESS WHERE WE MAY CONTACT YOU BY MAIL

STREET: _____ **APT:** _____

CITY : _____ **STATE:** _____ **ZIP CODE:** _____

COUNTY OF RESIDENCE: _____ **TOWNSHIP:** _____

HOME PHONE: ( ) _____ **MAY WE CONTACT YOU AT THIS NUMBER? YES NO**

CELL PHONE: ( ) _____ **MAY WE CONTACT YOU AT THIS NUMBER? YES NO**

WORK PHONE: ( ) _____ **MAY WE CONTACT YOU AT THIS NUMBER? YES NO**

IF NO TO ALL ABOVE NUMBERS, PLEASE PROVIDE A PHONE NUMBER WHERE WE MAY REACH YOU

CONTACT NUMBER: ( ) _____

EDUCATION

HIGHEST GRADE COMPLETED: _____

COLLEGE (NUMBER OF YEARS COMPLETED): _____

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CLIENT FINANCIAL DATA

EMPLOYMENT STATUS (PLEASE CHECK ALL THAT APPLY):

□ DISABLED □ EMPLOYED FULL-TIME □ EMPLOYED PART-TIME
□ HOMEMAKER □ SEEKING WORK □ NOT SEEKING WORK
□ STUDENT □ RETIRED □ SEASONAL EMPLOYMENT
□ OTHER (PROVIDE MEANS OF SUPPORT HERE): _____

YOUR PERSONAL INCOME (BEFORE DEDUCTIONS):

HOURLY WAGE $ _____ NUMBER OF HOURS WORKED PER WEEK: _____

HOW OFTEN ARE YOU PAID? (CHECK ONE) □ WEEKLY □ BI-WEEKLY □ MONTHLY □ OTHER

SPOUSE'S INCOME IF APPLICABLE (BEFORE DEDUCTIONS):

HOURLY WAGE $ _____ NUMBER OF HOURS WORKED PER WEEK: _____

HOW OFTEN ARE YOU PAID? (CHECK ONE) □ WEEKLY □ BI-WEEKLY □ MONTHLY □ OTHER

OTHER SOURCES OF INCOME (CHECK ALL THAT APPLY AND LIST AMOUNT RECEIVED):

□ WAGE SALARY $ _____ □ SOCIAL SECURITY $ _____ □ RENTAL INCOME $ _____
□ GRANT TUITION $ _____ □ PENSION $ _____ □ SSI $ _____
□ PARENT SUPPORT $ _____
□ PRIVATE GOVERNMENTAL/MILITARY $ _____
□ SELF-EMPLOYMENT (FARM) $ _____ □ SELF-EMPLOYMENT (NONFARM) $ _____
□ PUBLE ASSISTANCE/WELFARE/ADC $ _____
□ INTEREST/DIVIDENDS/ROYALTIES $ _____

TOTAL HOUSEHOLD INCOME : _____ # OF PEOPLE SUPPORTED BY THIS INCOME: _____

(Include parent/guardian income if client is under 18 years of age and parent is aware of the visit)

INSURANCE INFORMATION

□ PUBLIC INSURANCE (MEDICAID, GA, MEDICARE)
□ UNINSURED (NO PUBLIC OR PRIVATE INSURANCE) □ UNKNOWN/NOT REPORTED

□ PRIVATE INSURANCE (HMO, I.E., BLUE CARE, HEALTHPLUS, BCBS, ETC.)

SUBSCRIBER'S NAME (FIRST/LAST): _____

SUBSCRIBERS; DATE OF BIRTH (MM/DD/YYYY): _____