PERSONAL AND PREVENTIVE SERVICES
PERSONAL HEALTH CENTER 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): __________________
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) $ _____
- □ PUBLIC ASSISTANCE/WELFARE/ADC $ _____
- □ INTEREST/DIVIDENDS/ROYALTIES $ _____

TOTAL HOUSEHOLD INCOME: ___________________ (Include parent/guardian income if client is under 18 years of age and parent is aware of the visit)
- NUMBER OF PEOPLE SUPPORTED BY THIS INCOME: _______

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): ________________________________________________
- SUBSCRIBER’S DATE OF BIRTH (MM/DD/YYYY): _______________________________________

3/19, 6/19