KNOX COUNTY COMMUNITY Health Center
KNOX PUBLIC HEALTH

Annual Patient Demographics

Dear Patient: The Health Center provides low cost health care regardless of ability to pay. We are the Medicaid provider of choice; and accept Medicare and several insurance products. If you have these products or are "self-pay" you may qualify for a discount called a ***Sliding Fee Scale***. Nominal fees and payment arrangements are also available. To qualify for the "***Sliding Fee Scale***" you must provide Proof of Income and the household occupancy. (See the Sliding Fee Scale Application for further information.) We are required to collect personal information as a part of our FQHC grant agreement which is how we keep costs low. Thank you for your understanding and cooperation in providing this information.

Patient Information

Last Name: _____ First Name: _____ MI: _____

Previous names / aliases: _____ Date of Birth: _____

SSN: _____-_____-_____ Phone: _____ Cell Phone: _____

Address: _____ City:_____ State: _____

Zip Code: _____ County: _____ Student Status: ☐ Full Time ☐ Part Time ☐ Does not apply

How do you prefer to be reminded of your appointment: ☐ Text ☐ Call **Email Address**: _____
By providing email address you are acknowledging authorization to send correspondence by this medium.

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Language: ☐ English ☐ Spanish ☐ Other Do you need an interpreter: ☐ Yes ☐ No

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Race: ☐ White ☐ African American ☐ Asian ☐ Other (Please Specify) _____ ☐ Choose not to disclose

Ethnicity: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Unknown or choose not to disclose

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Gender at Birth: ☐ Male ☐ Female ☐ Other: _____

Current Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Unknown

☐ I chose not to disclose ☐ Other

Primary Care Physician:_____ City / State:_____ Phone: _____

Emergency Contact:

Last Name: _____ First Name: _____ MI: _____

Relationship to Patient: _____ Emergency Contact Telephone Number:_____

Annual Review: (***DO NOT*** complete this section – for staff instructed use only)

Signature of Patient / Responsible Party: _____ **Date:** _____

Complete if patient is 18 years of age or younger, attending school, or has a legal guardian:

For all minor patients (18 years of age or under), legal guardians will be asked to show documentation to prove that a legal relationship exists. This is for both the safety of the child and guardian and to ensure that the legally appointed parent or guardian is responsible for making medical decisions on behalf of the minor. Applicable legal documents pertaining to custody, divorce, separation, adoption or name change of parent of child are required.

Parent / Guardian Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

Current Custody Status: ☐ Parents ☐ Sole Parental Custody ☐ Joint Legal Custody ☐ DSS Custody ☐ Other: _____

Mailing Address (if different than patient): _____

Insurance Information:

Primary Insurance:	*Secondary Insurance*:
Insurance Company _____	Insurance Company _____
Participant's Name _____	Participant's Name _____
Participant's DOB _____	Participant's DOB _____
Participant's ID # _____	Participant's ID # _____

Required for statistical purposes and financial assistance

List number of people living in house (Please include self):_____

Annual Household Income (please check one): ☐ Less than $15,000 ☐ $15,000 to $24,999 ☐ $25,000 to $34,999 ☐ $35,000 to $49,000 ☐ $50,000 or more

Living Arrangements:

◯ **Shelter** (Safe havens, temporary overnight housing, armories)	◯ **Doubling Up** (Living with other people for temporary period and move often)	◯ **Permanent Residence** (Own, rent, apartment / room / house)
◯ **Transitional** (Center, Community Home)	◯ **Street** (Sidewalk, car, park, doorway, public or abandoned building)	
◯ **Other** (Hotel, motel, day-to-day single room occupancy)		

Do you live within Mount Vernon city limits: ☐ Yes ☐ No **Are you a veteran**: ☐ Yes ☐ No

To the best of my knowledge, the above information is complete and correct. I understand that I am responsible to let the doctor or staff know of any changes in my, or minor child's health, or demographic information.

I understand that I am responsible for notifying Knox County Health Center if there is a change in the insurance coverage, address or telephone number. I acknowledge that co-payments or nominal fees are due and payable on the day that services are received.

Name of Patient / Responsible Party (please print): _____ **Date:** _____

Signature of Patient / Responsible Party: _____ **Date:** _____