Walton County Health Department and Walton Community Health Center

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security Number** | **Sex at Birth (☑ one)** ☐ Male ☐ Female

Address | **City** | **State** | **Zip Code** | **County**

AKA (another name you go by or prefer to be called): | **Telephone Number and type:**

E-mail Address:

Gender (☑ one):
☐Male ☐Female ☐Transgender Male/Female-to-Male ☐Transgender Female/Male-to-Female ☐Other ☐Choose Not To Answer

Race (☑ one):
☐Asian ☐ Native Hawaiian ☐Other Pacific Islander ☐Black/African American ☐American Indian/Alaska Native ☐White

Primary Language Spoken: **Do you need an interpreter?** ☐ Yes ☐ No

Marital Status (☑ one):
☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced ☐ Unknown

U.S. Military Service (☑ one):
☐None ☐Currently Serving ☐Discharged

Ethnicity (☑ one): ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Are you a migrant worker or a family member of a migrant worker? ☐ Yes ☐ No

Living Quarters (☑ one):

☐Rent ☐Own ☐Live with family/friends ☐Homeless ☐Other Housing Arrangements ☐ Unstable

Advance Directives

I understand that I have the right to have an advance directive.

- ☐ I currently have an advance directive:
  - ☐ Living Will ☐ Health Care Surrogate ☐ Durable Power of Attorney for Health Care
- ☐ I do not have or want an advance directive
- ☐ I would like more information regarding advance directives

We encourage all patients to complete an advance directive, which allows you to state your preferences for medical treatments and to select an agent or person to make your health care decisions in case you are unable to do so or if you want someone else to make decisions for you. Further information on advance directives is available on our web site: http://Walton.floridahealth.gov

If you already have an advance directive, please bring a copy with you at your next visit. Your advance directive will be placed in your medical record.

FDOH-Walton/Walton Community Health Center does not deny anyone services because of race, national origin, skin color, religion, sexual orientation, physical handicap, disability, source of payment, or the inability to pay and uses recent Federal Poverty Guidelines to establish a sliding fee scale for eligible low-income patients. If you would like to apply for our Sliding Fee please make sure to complete the other side of this form.

SIGNATURE OF CLIENT/PARENT or GUARDIAN | SIGNATURE OF DEPARTMENT OF HEALTH EMPLOYEE | DATE

PATIENT ACCOUNT INFORMATION

Person responsible for payment:

Last Name	First Name	Middle Initial

Social Security Number	Date of Birth	Telephone Number and type:

Address (if different from patient)	City	State	Zip Code	County

INSURANCE INFORMATION

Do you have insurance that covers your health or dental condition? ☐ Yes ☐ No

Name of Insurance Company	Policy Number	Group Number

Name of the card holder (Insured)

I understand that I will be assigned to the full fee category and that I am responsible for any charges denied or not paid by my insurance. I also authorize the payment of medical benefits to the Walton County Health Department. Payment is due at the time services are rendered, unless prior arrangements have been made. Past due accounts may be referred to a collection agency.

SIGNATURE OF CLIENT/PARENT or GUARDIAN	SIGNATURE OF DEPARTMENT OF HEALTH EMPLOYEE	DATE

EMPLOYMENT

Employment Status	Employer:	What is your occupation?
☐ Employed ☐ Not Employed	Start Date:	

SLIDING FEE DETERMINATION

Enter income for your complete household or family unit - List each family member in household and include ALL types of income. *Documentation* will have to be provided in order to complete sliding fee determination.

NAME	Date of Birth	FAMILY RELATIONSHIP	Place of Employment or Other Source of Income	Income before Taxes or Deductions.
1.		Patient		$ WK BW MO
2.				$ WK BW MO
3.				$ WK BW MO
4.				$ WK BW MO
5.				$ WK BW MO
6.				$ WK BW MO
7.				$ WK BW MO
8.				$ WK BW MO

Do you pay child support? ☐ No ☐ Yes – **How much a month?** $_____

Do you pay for child care? ☐ No ☐ Yes – **How much a month?** $_____

I was provided a copy of the Primary Care/Family Planning Services Information sheet on _____. _____
Interview Clerk initials _____ (Date) (Pt. initials)