

Patient or Responsible Party Signature

			PATIENT IN	IFORMATION		
First Name(Legal)	Middle Initial	Last Nar	me	Previous Name	Date of Birth	Sex
Street Address	Apt. Number	mber		Patient Employer		
City	State	Zip Code	e	Patient's Occupation		
Home Phone Number		Social Security Number		Employer Street Address		
Cell Phone Number If not English, in v		vhat language do you wish to receive		Employer City/State/Zip		
Race: Asian Native Hawaiian	 Other Pacific I	slander	Black/African America	I an ⊡American Indian/Alaskan Native	☐Hispanic/Latino ☐	White Biracial
Annual Income:	Number of Persor	ns Suppoi	rted by this Income:	Do you wish to be considered for the discounted sliding fee schedule?		
Marital Status: Single Married Divorced Separated] Widow	Are you a veteran?	Are you currently in school?		
What is your current living situation? ☐ ☐ Homeless shelter ☐ Facing eviction		ice 🗌 T	1	Doubling up" with family or friends	Street or makeshift ho	using
			lumber	Employer Phone		
Spouse /Partner/Parent (If under 18)		Spouse/Parent Employer Name		Spouse/Parent/Partner Cell Phone		
Spouse /Partner/Parent (If under 18)		Spouse/Parent Employer Name		Spouse/Parent/Partner Cell Phone		
				FORMATION		Flot
Responsible Party/Custodial Parent		Phone Number		elationship to Patient Self Spouse Parent Other		
Street Address	Apt. Number			Responsible Party's Employer	Phone Number	
City	State	Zip Code		Social Security Number	Date of Birth	
PRIMARY INSURANCE nsurance Company Name and Address or Title 19				SECONDARY INSURANCE Insurance Company Name and Address or Title 19		
insulance Company Name and Address of The 13				' '		
Effective Date	Expiration Date			Effective Date	Expiration Date	
olicy Holder's Name		Relationship to Patient		Policy Holder's Name		Relationship to Patient
olicy Number		Group Number		Policy Number		Group Number
olicy Holder's Social Security Number		Policy Holder's Date of Birth		Policy Holder's Social Security Number		Policy Holder's Date of Birth
Policy Holder's Employer's Name				Policy Holder's Employer's Name		
Policy Holder's Employer's Phone Number				Policy Holder's Employer's Phone Number		
	ACC	EPTAN RIZATIO	CE OF FINANCIAL RES	I PONSIBILITY FOR THIS ACCOUNT MATION TO MY INSURANCE COMP	& PANY	
I hereby certify that the above information to my insurance company any medical	on is true. My s	ignatur	e below indicates I accep	t financial responsibility for this accou	nt. It also permits Linr	n Community Care to re
Patient or Responsible Party Signature				Relationship to Patient		Date
I authorize my insurance company to a	ssign benefits to	o Linn C	INSURANCE COMPA Community Care. This m	NY "Signature on File" eans my insurance company will pay l	inn Community Care	for services provided to
members of my family or me.						

Date