



# PATIENT INFORMATION AND INCOME DECLARATION

Today's Date: \_\_\_\_\_

Do you need language assistance (interpreter)? Y  or N

## Patient Demographics:

Legal Name: \_\_\_\_\_  
Last First Middle Last Name at Birth

Mother's Maiden Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN#: \_\_\_\_\_ Education (highest level completed): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Sex:  Female  Male

Gender Identity:  Transgender Female to Male  Transgender Male to Female  Agender  Nonbinary

Marital Status:  Married  Never Married  Divorced  Widowed

Race:  American Indian or Alaska Native  Asian  Black  African-American  Other  
 Native Hawaiian/Other Pacific Islander  White  Multi-Racial Ethnicity: Hispanic/Latino:  Yes  No

Language:  Arabic  Bosnian  Cambodian  Chinese  Creole  French  German  Hindu  Other  
 Hmong  Japanese  Korean  Laotian  Russian  Somali  Spanish  Vietnamese

How may we contact you? Check all that apply:  Mail  Email  Home  Other  Cell  Work

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_ May we leave a message?  Yes  No

## Financial Information:

Medicaid#: \_\_\_\_\_ Medicare#: \_\_\_\_\_ Peach Care#: \_\_\_\_\_

Private Insurance: \_\_\_\_\_ Other: \_\_\_\_\_ None: \_\_\_\_\_

**NOTE:** Some programs offer reduced fees based on income. To apply for a reduced fee, please provide the following information:

Number of family members in household: \_\_\_\_\_ Total family income: \$ \_\_\_\_\_ per **Week** or **Month** or **Year** (Circle one)

### STATEMENT OF ACCURACY OF INFORMATION PROVIDED:

I understand I am responsible for full payment of Dekalb Public Health, DKPH scheduled fees in cash, debit/credit card or a check from a Georgia Bank at the time of service unless I qualify for special discounted fees certain programs offer. Discounted fees are based on my income or my household's income and my number of dependents, which I have provided truthfully and accurately above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient, Parent or Guardian's Signature

## Consent for Release of Immunization Information into the Immunization Registry (GRITS)

The DKPH is authorized to release any immunization information and/or documents containing such information to the GRITS database.

I, \_\_\_\_\_ agree to have immunization information released into GRITS for the patient named above.

I, \_\_\_\_\_ decline to have immunization information released into GRITS for the patient named above.

## Photography Consent:

I consent for photographs to be taken of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record for the purposes of preventing identity theft. By consenting, I understand that I will not receive any payment. Refusal to consent will not affect the medical care I receive.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient, Parent or Guardian's Signature