FOR OFFICE STAFF ONLY

PATIENT NUMBER _____

DATE _____ CLERK _____

MEDICAID _____

SAGINAW COUNTY HEALTH DEPARTMENT
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): _____
SUBSCRIBERS; DATE OF BIRTH (MM/DD/YYYY): _____

PREFERRED PHARMACY & ADDRESS: _____

_____