PATHS
Live Life. Be Healthy.

Today's Date: ___/___/____

Which services are you interested in? ☐ Medical ☐ Dental ☐ Women's Health ☐ Behavioral Health ☐ MEDAssist ☐ Pharmacy

Who would you like to choose as your primary care provider? _____

What pharmacy do you prefer to use? ☐ PATHS Community Pharmacy ☐ Other _____

A. Patient Information

Name: _____ **Email**: _____

Address: _____ **City**: _____ **ST**: ____ **Zip**: _____
Do you live in public housing? ☐ Yes ☐ No ☐ Homeless

Phone (Home): _____-_____-_____ (**Cell**): _____-_____-_____ (**Work**): _____-_____-_____

Social Security Number: _____-_____-_____ **Date of Birth**: ____/____/_____

Birth Sex: ☐ Male ☐ Female

Gender Identity: ☐ Male ☐ Female ☐ Transgender - Male to Female ☐ Transgender - Female to Male ☐ Genderqueer, neither exclusively male or female ☐ Choose not to disclose

Sexual Orientation does not apply to patients under 18 years of age
Sexual Orientation: ☐ Straight (not lesbian or gay) ☐ Lesbian or Gay ☐ Bisexual ☐ Choose not to disclose ☐ Do not know ☐ Something Else, please describe _____

Race (check all that apply): ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Japanese ☐ Declined to Specify

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Declined to Specify

Preferred Language: ☐ English ☐ Spanish ☐ Other _____ ☐ Interpreter Needed

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

Accessibility Needs: ☐ Hearing Impaired ☐ Vision Impaired ☐ Interpreter Needed

Employment Status: ☐ Employed Full Time ☐ Employed Part-Time ☐ Unemployed ☐ Self Employed ☐ Retired ☐ On active military duty

Employer (or Name of School if Minor): _____

Are you a student? ☐ Yes ☐ No If yes, ☐ Full-Time ☐ Part-Time

Are you a veteran: ☐ Yes ☐ No

Are you a migrant/seasonal worker? ☐ Yes ☐ No

How do you prefer to be contacted? ☐ Mail ☐ Phone ☐ Email ☐ In Person

I authorize PATHS Community Medical Center to leave messages related to my care on my answering machine/voicemail ☐ Yes ☐ No

B. Responsible Party

Name of Person Responsible for this account: _____

Phone: (H) (_____) ___-____ _____Cell: (_____) ___-_____

Relationship to Patient: _____ **Birthday**: ___/___/___ SS **Number**: _____-_____-_____

Address: _____ **City**: _____ **ST**: ____ **Zip**: _____

Is this person also a patient in another of PATHS services? ☐ Yes ☐ No If yes, which one _____

C. Insurance Information

Primary Insurance
Name of Insured: _____ **Relationship to Patient**: _____ **Birthday**: ____/____/____

SS Number: _____-_____-_____ **Insurance Company**: _____

Subscriber Number: _____ **Do you have prescription coverage? ☐ Yes ☐ No**

Secondary Insurance
Name of Insured: _____ **Relationship to Patient**: _____ **Birthday**: ____/____/____

SS Number: _____-_____-_____ **Insurance Company**: _____

Subscriber Number: _____ **Do you have prescription coverage? ☐ Yes ☐ No**

D. Emergency Contact (This contact should also be listed on your HIPAA below)

In the event of an emergency while you are in our office, who should we contact?

_____ _____
Name **Relationship**

_____ _____ _____ _____
Address **City** **ST** **Zip**

(_____)_____-_____ (_____)_____-_____ (____)_____-_____
Phone: Home **Phone: Cell** **Phone: Work**

E. Health Record Release Authorization (HIPAA)
Disclosures to Family & Friends: I authorize disclosures of my health/dental information, relevant to current treatment to:

Name & Relationship: _____ **☐ In Person ☐ By Phone**
Phone Number: _____

Name & Relationship: _____ **☐ In Person ☐ By Phone**
Phone Number: _____

Name & Relationship: _____ **☐ In Person ☐ By Phone**
Phone Number: _____

All-inclusive signature: _____ **Date:** ____/____/_____
If you want any of your health records released, this page MUST be signed.

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SLIDING FEE SCALE APPLICATION

If you have insurance and do not wish to apply for the sliding fee scale, please initial here: _____

Patient Name (Printed): _____ Date: ____ / ____ / _____

Date of Birth: ____ / ____ / _____ **Do you file taxes? ☐ Yes ☐ No**

How many in your household are dependent on this income? _____ (include yourself)

Please complete the following:

Name (Spouse): _____ ____ - ____ - _____ (SS#) ___ / ___ / _____ (Date of Birth)

Name (Child/Dependent): _____ ____ - ____ - _____ (SS#) ___ / ___ / _____ (Date of Birth)

Name (Child/Dependent): _____ ____ - ____ - _____ (SS#) ___ / ___ / _____ (Date of Birth)

Name (Child/Dependent): _____ ____ - ____ - _____ (SS#) ___ / ___ / _____ (Date of Birth)

Name (Child/Dependent): _____ ____ - ____ - _____ (SS#) ___ / ___ / _____ (Date of Birth)

Name (Child/Dependent): _____ ____ - ____ - _____ (SS#) ___ / ___ / _____ (Date of Birth)

How often do you get paid? ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually ☐ Does not apply

Please list your gross income for everyone in your household:

Salary Wages:	$_____	Social Security:	$_____
Interest on Savings Accounts:	$_____	Dividends on Investments:	$_____
Pension	$_____	Personal Business Profits:	$_____
Rental Income:	$_____	Disability:	$_____
Unemployment:	$_____	Alimony:	$_____
Veteran's Benefits:	$_____	Child Support:	$_____
Aid to Dependent Children:	$_____	SSI:	$_____
Other: _____	$_____	Other: _____	$_____

Total Annual Income: $_____

The information provided concerning the size of my family and my family's gross annual income from all sources is true, accurate, and complete to the best of my knowledge. I realize that PATHS Community Medical/Dental Center will rely on such information to determine how much my account will be discounted. I realize that knowingly giving false information in this case may result in criminal prosecution under the laws of Virginia. I agree to report any change in either my income or my family size to PATHS. PATHS may initiate a review of my payment status at any time to verify the information I have provided.

Signature: _____ Date: ____ / ____ / _____

For Front Desk Use Only:

Sliding Scale Type: _____ **Sliding Fee Scale Expiration Date**: ____ / ____ / _____ **Initial**: _____