DEMOGRAPHIC INFORMATION

Last Name _____Legal 1st Name _____ MI _____

DOB _____ Sex assigned at Birth M ___ F ___
Race Please Check: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White Hispanic Yes ___ No ___

Phone # _____
Home Address 911 _____
City _____ ZIP_____ County of Residency_____
Mailing Address _____
City _____ ZIP _____ Email Address: _____
Marital Status - Single _____ Married _____ Divorced _____ Separated _____ Widow/Widower _____
Emergency Contact Name _____
Relationship _____ Phone # _____
Do you have Health Insurance? Yes ___ No ___

INS. Co. Name_____Policy/Member#_____

Policy Holder_____ DOB _____
I understand that I have insurance that should pay for my visits at a participating provider. I understand that the Dixie County Health Department is not a participating provider for all insurances. The Health Department will attempt to bill my insurance; if my insurance denies the claim, I understand that I will be responsible for the charges. I understand that I may apply for sliding scale based on my income. I understand that all programs are not covered by sliding scale and may be charged at full fee.

If I decide to come to the Health Department for my care I understand that I will be charged and expected to pay a fee if appropriate at each visit. I also understand that if I access care from a provider who accepts my insurance that my visits should be paid for by my insurance.

Please list all family members living in your home and note monthly income if applicable
(Income includes all earnings from jobs, pensions, child support, social security, death benefit, alimony, unemployment/worker's compensation, veteran benefits, investments, trust funds, rental income, self-employment, Public Assistance, grants or any other income received.)

Name	Date of Birth and Relationship	Race	Employer or Income Source	Monthly Income

Are you paying child care? Yes _____ No _____ Monthly Amount _____
Do you pay court ordered child support for any child not living in your home?
Yes _____ No _____ Amount$ _____
Pregnant Yes ___ No ___ Expected Delivery Date _____ Number Unborn_____

I affirm the information I am providing is true and correct to the best of my knowledge. I understand if I provide false or inaccurate information services may be discontinued and I may have to pay for all services received according to the appropriate fee schedule.

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Signature _____ Date _____