RETURNING PATIENT REGISTRATION INFORMATION

HOPE CLINIC OF ROSS COUNTY

PLACE LABEL HERE

Patient Number

TODAY'S DATE: ___________________________

REASON FOR VISIT: ____

IDENTIFYING INFORMATION: [PLEASE PRINT]

Legal Name (First and Last)____

Male______ Female _____ Married ____ Widowed_____ Single_____ Divorced_____

PREFERRED CONTACT INFORMATION: ☐ **No change since last visit**

Phone: _________________________ Email: _____________________________________

Other: ___________________________________

ADDRESS: ____ City: ______________

County:___________ State:_______ Zip: ___________

I am interested in receiving more information on the following:

Prayer Support ___ Dental ___ Pharmacy___ Vision Services____ Community Resources ___

300% Federal Poverty Guidelines for 2023. (For each additional person, add $5,140)

Family Size	Annual Income
1	$43,740
2	59,160
3	74,580
4	90,000
5	105,420
6	120,840

Are you eligible to receive treatment under any governmental healthcare program such as Medicaid, Medicare, Disability, Medical Assistance, etc? Yes_______ No _______

Do you have private health insurance of any kind?

Yes ______ No _______

Do you make more money than the income range listed here based on your family size? Yes ____ No ____

- ❑ If you answered yes to any of the questions, please see someone at the front desk for referral information.
- ❑ If you truthfully answered NO to ALL questions, you qualify and may continue to sign and complete the remaining forms.

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PATIENT SIGNATURE DATE