Hopewell Health Centers, Inc.

Help us get to know you! By supplying the requested information below, our team can work together to meet your individual needs.

Patient Information

_____ Date of Birth _____ Social Security #_____

Last First M

_____ Phone _____ Cell_____ Msg/Work_____

Address (Street and Post Office)

_____ Email Address_____

City State Zip County

Employer_____

Responsible Party ____Self ____Other

Relationship _____

_____

Name

_____

Address

_____

City State Zip Phone#

Preferred Pharmacy _____

Emergency Contact Information

Name_____ Phone _____ Relationship_____

Insurance

Primary Insurance _____

Policy Holder_____

Name

Social Security #_____ DOB_____

Insurance ID # _____

Employer_____

Address_____

Secondary Insurance_____

Policy Holder_____

Name

Social Security#_____ DOB_____

Insurance ID # _____

Employer _____

Address_____

(Circle One) Birth Sex: Male Female Unknown

Sexual Orientation: Lesbian, Gay or Homosexual Straight Bisexual Something Else_____
Don't know Choose not to disclose

Gender Identity: Male Female Transgender (female to male) Transgender (male to female) Neither exclusively male nor female
Other_____ Choose not to disclose

Marital Status: Single Married Divorced Partner Unknown Widowed Legally Separated

Veteran? Yes No **Learning Preference:** Oral Visual Written **Language:** English or Other: _____

Race: White Black African American American Indian Alaska Native Asian Native Hawaiian
Other Pacific Islander Other Race_____ Decline to specify

Ethnicity: Hispanic or Latino Not Hispanic or Latino Other_____ Decline to specify

Financial Information

Total Number of Household Members _____ Total Income $_____

List Household Members (A Household is defined as a group of two or more persons related by birth, marriage, adoption, or guardianship living in the same household):

Name	DOB	Relationship

Proof of Income must be provided to receive a sliding fee discount.

Provide proof of income for all household members –pay stubs, child support,

unemployment, disability, social security (must be award/benefit letters).

_____ I am refusing the sliding fee discount.
_____ I certify that I have no income of any kind.
_____ I am applying for Sliding Fee and will provide proof of income.

For Office Personnel Use Only:
Sliding Fee %_____ Sliding Fee Expiration_____

I certify that, as of this date, the above information is correct to the best of my knowledge.
I authorize payment of all insurance policy benefits to be paid directly to Hopewell Health Centers, Inc. This will include information necessary to determine eligibility for public funds for behavioral health services, to enroll me/my child in GOSH, and to obtain payment for treatment rendered which is submitted to appropriate ADAMHS Board or the county of my residence. I also understand that failure to notify Hopewell Health Centers, Inc. of any additions or corrections will terminate my eligibility for the sliding fee, should I qualify.
Any false statement will jeopardize the discount and result in the requirement of full payment of my account.

Patient Signature _____ **Date** _____
Parent or Legal Guardian_____ **Date** _____
Employee Signature_____ **Date** _____