New Patient Application

PAYMENT FOR SERVICES RENDERED IS DUE AT EVERY APPOINTMENT ATTENDED.
NO-SHOWS WILL INCUR A $25.00 CHARGE UPON ATTENDANCE AT THE NEXT SCHEDULED APPOINTMENT.

Patient Name: _____ **Today's Date**: _____

Date of Birth: _____ **Age 18-64**: _____ **Social Security #** _____

Physical Address (No P.O. Box): _____

City _____ **State** _____ **Zip** _____ **County** _____

Kendall County Resident? Yes ☐ No ☐ **Area**: Boerne ☐ Comfort ☐

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Language Spoken: English ☐ Spanish ☐ Other ☐ _____

Have you ever received services at HCMfH? Yes ☐ No ☐ If so, when? _____

Male ☐ Female ☐ Females: **Are you pregnant?** Yes ☐ No ☐

Marital Status: ✓ One	Single	☐	Married	☐	Divorced	☐	Separated	☐	Widowed ☐
Race: ✓ One	African American	☐	Asian	☐	Caucasian	☐	Hispanic Latino	☐	Native American ☐
	Pacific Islander	☐	Other: (Describe)						

Do you currently have Health Insurance? No ☐ Yes ☐ if yes, what type? Check (✓) one below:

Medicaid	Medicare	Affordable Care Act	VA Health Benefits	Worker's Compensation	Other
☐	☐	☐	☐	☐	☐
Please explain "Other":					

Are you currently employed? Yes ☐ No ☐ Name of Employer: _____

Are you a Veteran? Yes ☐ No ☐

Do you have photo ID? Yes ☐ No ☐ (You must bring a photo ID to the first visit. A copy of your ID will remain confidential and is located within your patient chart.)

Emergency Contact: _____ **Telephone Number:** _____
(PLEASE ADD THIS NAME TO THE "***OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION***" FORM.)

What medical services are needed now?

Name of practice where previous medical care was received: _____

How did you hear about this clinic? _____

Church Affiliation? _____

TURN PAGE OVER TO COMPLETE

HILL COUNTRY MISSION FOR HEALTH

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Family Members living at home, including you:

Name (The first person on list is yourself)	Relationship (Spouse/Child)	Social Security #	Sex M/F	Date of Birth (MO/Day/YR)	Work (Yes/No)	Income

Is any member of your family ***RECEIVING*** any of the following?

☐ Yes ☐ No	Medicaid	☐ Yes ☐ No	Workman's Compensation
☐ Yes ☐ No	VA Medical	☐ Yes ☐ No	Alimony
☐ Yes ☐ No	Unemployment Benefits	☐ Yes ☐ No	Pension Benefits
☐ Yes ☐ No	Social Security Income	☐ Yes ☐ No	SSI – Supplemental Security Income
☐ Yes ☐ No	TANF	☐ Yes ☐ No	Child Support
☐ Yes ☐ No	Food Stamps	Other:	

I certify that the information I have given is up-to-date and correct. I understand that any falsification, misrepresentation, or withholding of information will result in the loss of eligibility to receive clinic services.

Printed Name:_____Signature:_____Date:_____

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BELOW SECTION TO BE COMPLETED BY CLINIC STAFF

New Applicant ☐ Renewal Applicant ☐

Your total income (including spousal income) Monthly:_____ Annually:_____

Income Verification Includes: previous year's income tax return, unemployment benefits, child support, disability check, retirement check, three months of paycheck stubs, food stamp verification, rental income, and all other proof of income. **Proof of income will be verified prior to patient seeing provider.**

Photo ID Includes: driver's license, passport, visa, immigration documents, student or work, photo ID from other country, or other form of photo identification. **Valid Photo ID will be verified prior to patient seeing provider.**

Type of Photo ID received_____Type of Income Verification received _____

Printed name of Clinic Staff_____Date_____