Salina Family Healthcare Center
A Federally Qualified Community Health Center
651 E. Prescott, Salina, KS 67401
Medical Center ~ (785) 825-7251
Dental Center ~ (785) 826-9017
Pharmacy ~ (785) 452-3900
www.salinahealth.org

Chart Number: _____

Patient Information

The following information helps us take better care of you. All information obtained is handled in a private and confidential manner. Any blank will be considered a "declined to comment".

Patient Name: DOB: Social Security Number:

Address: City/State: Zip:

Is this public Housing? **Yes** **No**

Home Phone Number: Work: Cell:

Email Address: Preferred method of contact: Phone ☐ E-Mail ☐ Letter ☐ Text ☐

Regardless of what services you are receiving at Salina Family Healthcare Center, please fill out the following information regarding your health insurance:

Carrier Name: **ID #**: **Group #**:

Emergency Contact:

Name: How Related: Phone Number:

Please list, by name and specialty, any healthcare providers you see outside of Salina Family Healthcare Center (ex: OB/GYN, GI, Cardiologist, Therapist, etc.):

_____

_____

Please circle the best option(s) per category below for all that pertains to the patient named above:

Race
- White
- Black / African American
- Asian
- Native Hawaiian
- American Indian/Alaskan Native
- Other Pacific Islander

Ethnicity
- Hispanic/Latino
- Not Hispanic/Latino

Veteran
- Veteran
- Not a Veteran

Preferred Language
- English
- Spanish
- Vietnamese
- Sign Language
- Other (please specify) _____

Gender: Male Female

Have you been homeless at anytime in this calendar year? Yes No

Are you a seasonal or migrant farmworker? Yes No

See Reverse Side

Household Size and Income ***(Under the number of people in your household, circle the range of income that pertains to you):***

1 Person	**2 People**	**3 People**	**4 People**
$0 - $11,770	$0 - $15,930	$0 - $20,090	$0 - $24,250
$11,771 - 17,666	$15,931 - 23,895	$20, 091 – 30,135	$24,251 – 36,375
$17,656 – 23,540	$23,896 – 31,860	$30,136 – 40,180	$36,376 – 48,500
Over $23,540	Over $31,861	Over $40,181	Over $48,501

5 People	**6 People**	**7 People**	**8 People or More**
$0 – $28,410	$0 - $32,570	$0 - $36,730	$0 - $40,890
$28,411 – 42,615	$32,571 – 48, 855	$36,731 – 55,095	$40,891 – 61,335
$42,616 – 56,820	$48,856 – 65,140	$55,096 – 73,460	$61,226 – 81,780
Over - $56,821	Over - $65,141	Over - $73,461	Over - $81,781

Permission to Release Health Information: ***(List the names of family and/or friends we may release information about your healthcare to.)***
This consent shall remain in effect until a new list is provided or until revoked, in writing.

☐ **None**

1) _____

2) _____

3) _____

Assignment of Benefits and Authorization to Release Medical Information

I request that payment of authorized benefits from Medicare, Medicaid and/or any insurance carrier applicable, be made to me, or on my behalf, to Salina Family HealthCare Center, for any services furnished to me and/or my dependent family members by my provider. I authorize any holder of medical/dental information about me and/or my family members to release it to the Division of Family Services, the Centers for Medicare and Medicaid Services (CMS), applicable insurer(s), and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits or the benefits for other related services.

- By my signature below, I am agreeing to the Financial Account policies set forth by Salina Family Healthcare Center. A detailed description of the Financial Account Policy is available for all patients, upon request.
- I have also disclosed all insurance coverage in effect at the time services were provided to me. I understand that failure to inform Salina Family Healthcare Center of any third party insurance coverage will be considered fraud and I understand that the clinic will prosecute to the fullest extent to the law.

Patient/Legal Guardian Signature: _____

Today's Date: _____

For Internal Use Only:
_____ Front Desk
_____ Practice Partner Scanned
_____ Dentrix Scanned