Chart #__________ **CAREFUL CONTACT YES____ NO___**

Are you able to read English: ☐YES ☐NO Are you able to understand spoken English: ☐ YES ☐NO

FAMILY REPRODUCTIVE HEALTH
Chadron, NE Phone: 308-432-8979

CLIENT INFORMATION SHEET

Client name____ Birth date__________ Age_____
Last First Middle Initial Maiden

Address: _____________________________________ Home#______________ Cell #______________

____
City State Zip County

ADDRESS CHANGE**____ *****Date of change*****_______**

I work: ☐full time ☐Part time ☐I do not work I go to school: ☐full time ☐part time
I live with: ☐Spouse/partner ☐Parents ☐Others ☐Alone How many people reside in your home_______

We must be able to contact you in some way: Please check all the ways we may contact you:
☐Call home ☐Call cell phone ☐Call work #__________________ ☐Mail at home ☐E-mail ☐Other

Because we receive federal funds, we must collect this information about you: **You may check more than one:**

☐White ☐African American/Black ☐American Indian/Alaskan Native ☐Asian Pacific Islander/ Native Hawaiian ☐Unknown ☐Declined
Please check only one of the following: ☐Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐Unknown

Are you covered by public health insurance such as Medicaid, Kids Connection OR do you have insurance? ☐YES ☐NO
(**Please provide office staff with insurance or Medicaid card**)

I authorize release of information from my file to my insurance carrier with payments sent directly to this office. Please initial________

☐ I wish to apply for reduced fees and will give staff complete and honest information about my income
☐ I do NOT wish to apply for reduced fees.

LIST ALL SOURCES OF FINANCIAL SUPPORT **(show all amount before deductions/taxes)**

	monthly amount:	*Yearly or needed* Changes:
Your employment	_______________	__________
Spouse/partner	_______________	__________
Parent (s)	_______________	__________
Child Support and/or Alimony	_______________	__________
SSI, Unemployment compensation	_______________	__________
Social Security, pension, railroad retirement, insurance & annuity payments	_______________	__________
Dividends, interest, rental income, trust funds	_______________	__________
Other sources (tips, allowances, etc)	_______________	__________

How many people does this support _________

Changed to Scale______ Date changed __________Staff initials__________

I understand that I am responsible for paying fee's for services if I fall on a paying scale. I also understand that donations are always appreciated and encouraged.

Client Signature____ Date________________
This medical record is confidential & will not be released to anyone without your written consent except as may be required by law
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For Office Use Only: Verified total monthly income: ☐YES ☐NO If yes, how___________________
INCOME CODE: A (1) B (2) C (3) D (4) E (5) ☐Insurance ☐Medicaid ☐EWM
Staff initials / date____________________________

CONFIDENTIAL