NEW PATIENT APPLICATION

Patient Name: _____ **Date of Birth**: _____
Last First Middle

Address: _____
Street or P.O. Box Apt/Unit City State Zip

Telephone: _____ _____ _____
Home Mobile Work

Email: _____ **Social Security #:** _____

Gender: _____ **Preferred Language:** ☐ English ☐ Spanish ☐ _____

Race & Ethnicity: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Prefer not to disclose

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact: _____
Name Relationship Phone Number

Are you employed? ☐ No ☐ Yes, at: _____

Are you currently homeless? ☐ No ☐ Shelter ☐ Street ☐ Living with friend or relative

Do you have health insurance? ☐ No ☐ Medicaid ☐ Medicare ☐ Other: _____

Have you applied for Medicaid in the past 12 months? ☐ No ☐ Yes, Date: _____

Do you have a regular doctor? ☐ No ☐ Yes: _____
Doctor or Practice Name

Do you have a regular dentist? ☐ No ☐ Yes: _____
Doctor or Practice Name

Do you regularly take any prescription medications? ☐ No ☐ Yes: _____
# of prescriptions

Have you been to an Emergency Room in the past 12 months? ☐ No ☐ Yes: _____
# of times

How many people live in your household? _____

List the name, age, and monthly income for each member of your household, starting with you. Add lines if needed.

Name	Age	Wages ($)	Soc. Sec./ Disability ($)	Retirement ($)	Workers Comp / Unemployment ($)	Food stamps / Alimony / Child Support ($)	Other Income ($)	**Total Monthly Income ($)**

Total Monthly Household Income: $_____

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PATIENT DISCLOSURE & AGREEMENT

By signing this form, I attest that this information is true and accurate.

I agree that if I enroll with any medical insurer (including but not limited to Medicaid & Medicare programs) or if my financial situation changes that I will immediately notify Ebenezer Medical Outreach, Inc. I understand that failure to do so will result in my dismissal from the program.

I understand that Ebenezer Medical Outreach, Inc. does not provide narcotics or any controlled medication, including anti-anxiety medications such as Xanax, Valium, Ativan, Ultram, Neurontin, or Klonopin.

I agree to allow Ebenezer Medical Outreach, Inc. to complete any patient assistance program enrollment process on my behalf, which may include disclosure of personal & medical information, soft credit checks, and other information necessary to determine eligibility for available drug manufacturer programs to secure my prescribed medication. I understand that my information will be kept confidential, secure, and only available to licensed prescribers and Ebenezer Medical Outreach, Inc. staff.

I agree to allow pharmaceutical company auditors to review my information as needed for participation in patient assistance programs.

_____ _____ _____

Patient Signature *Date* *EMO Staff Qualifier Signature*

NECESSARY DOCUMENTATION

To receive health care services, you must provide proof of identity in the form of a **Photo ID**. If you have health insurance, you must provide your **current insurance card**.

If you are uninsured and seeking free services, you must also provide **proof of income** upon joining our program and at least annually after that. Documentation includes one or more of the following:

- Form 1040 or 1040A (Tax Return)
- Form 4506-T (if you don't file incomes taxes)
- 1099 Benefits Statement (if you are on Social Security)
- W-2 from Employer
- Pay Stubs for One Month

If you are uninsured and seeking free prescription medication through our Community Pharmacy, you must provide a **Medicaid denial** letter from the past 12 months upon starting at our pharmacy and at least annually after that.

DOCUMENTATION AGREEMENT

I have read and understand what documentation I need to provide and will do so as required.

_____ _____

Signature *Date*