



Desoto County Health Department Patient Triage Form

DeSoto County Health Department

INFORMATION: ARE YOU A NEW PATIENT YES NO

Last name:	First:	Middle:	Birthdate:
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Street address:	Home Phone Number: ()	Social Security Number:
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P.O. box:	City:	State:	ZIP Code:
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Emergency Contact (Not Living With You): Name:	Phone:
Address:	

OTHER INFORMATION:

STATUS: Single Married Separated Divorced Widowed

INSURANCE INFORMATION NONE GROUP # ID #

			Phone:
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HOUSEHOLD STATUS/EMPLOYMENT INFORMATION:

Name of Employer:	Phone:
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OTHER INCOME:

Social Security
 Child Support
 Retirement
 SSI
 AFDC/Food Stamps
 VA Benefits
 Unemployment Benefits
 Worker's Compensation
 Contributions from friends/relatives
 Student Loans
 None

REASON FOR VISIT: PLEASE LIST YOUR PRESENT HEALTH CONCERNS, PROBLEMS OR SYMPTOMS:

AUTHORIZATION FOR TREATMENT

I HEREBY CERTIFY THAT ALL INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I HEREBY APPLY FOR AND GRANT PERMISSION TO RECEIVE ALL NECESSARY MEDICAL TREATMENT AVAILABLE THROUGH THE DESOTO COUNTY HEALTH DEPARTMENT FOR MYSELF AND/OR MY FAMILY.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DESOTO COUNTY HEALTH DEPARTMENT FOR ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE, FOR SERVICES RENDERED.

Client/Parent/Guardian/Responsible Party

DATE

**YOU ARE REQUIRED TO COMPLETE THE FOLLOWING FOR A SLIDING
SCALE DISCOUNT BASED ON TOTAL FAMILY INCOME.**

HEAD OF HOUSEHOLD INFORMATION			
Last name:		First:	Middle:
Relationship:			
Employed by:		Phone:	
Total Income:		<input type="checkbox"/> Weekly <input type="checkbox"/> Bi- weekly <input type="checkbox"/> Monthly	
WAGE EARNER #2			
Last name:		First:	Middle:
Relationship:			
Employed by:		Phone:	
Total Income:		<input type="checkbox"/> Weekly <input type="checkbox"/> Bi- weekly <input type="checkbox"/> Monthly	
LIST ALL HOUSEHOLD MEMBERS			
NAME	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY NUMBER
SELF			
1.			
2.			
3.			
4.			
5.			
6.			