



# 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.**

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