

# Desoto County Health Department Dental Clinic Triage Form

<b>INFORMATION: ARE YOU A NEW PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO</b>			
Last name:	First:	Middle:	Birthdate:
Street address:		Home Phone Number: (    )	Social Security Number:
P.O. box:	City:	State:	ZIP Code:
Emergency Contact (Not Living With You): Name:			Phone:
Address:			
<b>OTHER INFORMATION:</b>			
STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
<b>INSURANCE INFORMATION <input type="checkbox"/> NONE      GROUP #      ID #</b>			
			Phone:
<b>HOUSEHOLD STATUS/EMPLOYMENT INFORMATION:</b>			
Name of Employer:			Phone:
<b>OTHER INCOME:</b>			
<input type="checkbox"/> Social Security <input type="checkbox"/> Child Support <input type="checkbox"/> Retirement <input type="checkbox"/> SSI <input type="checkbox"/> AFDC/Food Stamps <input type="checkbox"/> VA Benefits <input type="checkbox"/> Unemployment Benefits <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Contributions from friends/relatives <input type="checkbox"/> Student Loans <input type="checkbox"/> 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
<b>SELF</b>			
<b>1.</b>			
<b>2.</b>			
<b>3.</b>			
<b>4.</b>			
<b>5.</b>			
<b>6.</b>			