UMSS
your health matters

PATIENT INTAKE AND FINANCIAL ELIGIBILITY FORM

☐ New Patient

Last Name	Middle Name	First Name

Male	Female
☐	☐

Date of Birth	SSN/ ID

Address:

Street:	Phone-Cell:
City: State: Zip:	Phone-Home:
E-Mail:	Text SMS ☐

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

Race:

☐ African American ☐ Asian ☐ White ☐ Hispanic ☐ Native American ☐ Other

If you were referred by a Hospital? Check one:

☐ Central Florida Regional ☐ Orlando Health ☐ Advent Hospital ☐ Other

How did you hear about us (UMSS)?

☐ Word of Mouth ☐ Television News ☐ Newspaper ☐ Hospital ☐ Other -

Reason for Visit :

Family Size: Adults____ Under 18 ____ 18-21--Student ____ Unborn _____ Family Size TOTAL _____

FAMILY MEMBERS NAME (First and Last)	**DOB**	**EMPLOYER**	**GROSS EARNED INCOME LAST 4 WKS**	**GROSS UNEARNED INCOME LAST 4 WKS** (Do not include TCA or SSI)
SELF			**$**	**$**
SPOUSE/PARTNER			**$**	**$**
CHILD			**$**	**$**
CHILD			**$**	**$**
CHILD			**$**	**$**
CHILD			**$**	**$**
		TOTALS	**$**	**$**
		Add earned and unearned income to determine total		**TOTAL INCOME $_____**