

PATIENT PROFILE

Chart Number: _____

WELLNESS CENTER OF DOOR COUNTY. Inc

PO Box 85, Sturgeon Bay, WI 54235

Name: _____
 First Middle Last

Age: _____ Date of Birth: ____/____/____ Social Security Number: _____

Race: Caucasian Hispanic African American Native American Asian other: _____

Marital Status: Single Separated Married Divorced Widowed

Address: _____
 Street or PO Box City State Zip

WISCONSIN County in which you reside: Door Kewaunee Brown Other: _____

If above is NOT your permanent year-round address, please provide:

Address: _____ City _____ State _____ Zip _____

Email: _____

Phone: (____) _____ (____) _____ (____) _____
 Home cell/pager work

Which # may we leave a vague message on (e.g. call the Wellness Center)? __ home __ cell

May we leave a specific message on your cell phone? __yes __no

If you are under the age of 21 and still live with your family:

- Do your parents know you're coming to the Wellness Center of Door County? yes no
- May we identify ourselves as Wellness Center if we need to call you?
 yes no Caller is to identify themselves as: _____
- Please check the ways in which we may contact you: call home call work call cell phone
 send letter to home send *plain envelope*/letter

EMERGENCY CONTACT INFORMATION:

(In the event we need to contact you about abnormal test results...we will need to be able to identify ourselves to them; no results/information will be shared with them)

Name: _____ Relationship: _____

Address: _____ City _____ State _____ ZIP _____

Phone: (____) _____

Please complete reverse side of this form

FINANCIAL WORKSHEET

Fees in our clinic are charged on a sliding fee scale based on the **income of people in your household**. A household is defined as those people living together and sharing expenses and those dependents (children) you're responsible for. The questions below are necessary to determine your eligibility for a discount from our full charges.

Do you live alone or with: partner parents/guardian husband/wife children: #_____

Do you have a primary care provider or physician that you typically see? Yes No

Do you have *any* health insurance, including Medicaid/Forward/Badger Care? yes no

If yes, Name of Insurance Company _____ Please **show us your card**

Do you have dental insurance/coverage? yes no

How did you learn about us? Friend Relative Phone Book Newspaper Ad Drive-by
 Poster Social Services Help Of DC MD Other: _____

School/Employment/Income:

Current student at: Southern Door Sturgeon Bay Sevastopol Gibraltar
 Algoma Kewaunee Luxemburg/Casco College: _____

Employer: _____ **Job:** _____ **Start Date:** _____
#hours per week _____ **@ \$** _____ **/hour** **gross weekly salary** \$ _____

How much other money do you receive on a weekly basis?
 (allowance, tips, unemployment, child support, alimony, etc) \$ _____

If you live with a spouse.....please estimate their..... **gross weekly salary** \$ _____

TOTAL WEEKLY INCOME: \$ _____

Certification Statement:

I certify that the information provided is true & complete to the best of my knowledge & truly represents my financial status; and I AUTHORIZE the Wellness Center to verify any information given on this application to assist in their determination of my eligibility for care.

 Patient Signature

 Date

FOR STAFF USE ONLY

Total weekly income: \$ _____ #/persons supported by income: _____ Fee Level: _____

Policy Variance Documentation: _____

Date	Address	City/Zip	Home/Cell #	Job/Salary	Work #	Level