

CLIENT / MEMBER INFORMATION

For office use only

Date ___/___/___ Membership Type: Basic Enhanced Membership Card # _____ Amount Paid: \$ _____
 Paid by: Check # _____ Charge Cash Membership Effective ___/___/___ Membership Expiration ___/___/___
 Insurance #: _____ (att copy of insurance card) Entered in eTapistry: ___/___/___ Entered by _____

Confidential Personal Information - PLEASE PRINT

Your personal information will not be shared! It will be used only to compile the aggregate statistical reports that are required by most of the agency's funding sources. Thank you for your help.

Circle Ethnicity: Asian Black Black Hispanic Caucasian Hawaiian/Pacific Native American White Hispanic Other _____

Circle One: Mr. Mrs. Miss. Ms. Dr. Other Gender: Female Male Marital Status: _____

First Name _____ Middle _____ Last _____ Nickname _____

Home Address _____ City _____ State _____ Zip _____

E-Mail Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Date of Birth _____ Medicare # _____ Medicaid # _____

PLEASE CIRCLE WHAT APPLIES: INCOME LEVEL (monthly as of 10/2020)

<i>Family size of 1:</i>	less than \$1063.00	less than \$1,414.00	less than \$1,595.00	less than \$2,127.00	less than \$2,127.00	more than \$3,190.00
<i>Family size of 2:</i>	less than \$1,437.00	less than \$1,911.00	less than \$1,983.00	less than \$2,155.00	less than \$2,873.00	more than \$4,310.00

Emergency Contact Person _____ Relationship _____

E-Mail Address _____

Address _____ Telephone # _____ Cell Phone # _____

Primary Care Physician _____ Telephone # _____

HOW DID YOU HEAR ABOUT THE CENTER? CIRCLE ONE:

Newsletter Newspaper Medical Professional PLE Vehicle Radio Relative Social Media

PrimeLife Staff Web Site TV Other _____

HAVE YOU RECENTLY MOVED TO THE AREA? Yes No

WITHIN THE LAST YEAR, HAVE YOU RETIRED OR LOST A SPOUSE? Yes No

ANY MEDICATIONS (S) THAT MUST BE ADMINISTERED IN CASE OF EMERGENCY? CIRCLE ONE: YES NO

DO YOU CARRY A LIST OF MEDICATIONS? _____ LIST MEDICATIONS HERE _____

DO YOU CARRY IT ON YOUR PERSON? CIRCLE ONE: YES NO WHERE? _____

FOOD AND MEDICAL ALLERGIES? PLEASE LIST _____

HEALTH ISSUES _____