FLORIDA DEPARTMENT OF HEALTH IN OSCEOLA COUNTY
PATIENT DATA FORM

Rick Scott, Governor
John H. Armstrong MD, FACS State Surgeon General

SECTION 1

Name: _____ **SSN:** _____ **Date of Birth:** _____

Address: _____ **Gender:** ☐ **M** ☐ **F**

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Martial Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race: ☐ Asian ☐ Black ☐ Native American ☐ White ☐ Other _____ **Ethnicity (Hispanic):** ☐ **Y** ☐ **N**

Have you ever received care at the Osceola County Health Department? ☐ **Y** ☐ **N**

If, so where? ☐ Boggy Creek ☐ Stadium Place ☐ St. Cloud ☐ Poinciana

Have you ever been diagnosed or had any of the following conditions?

☐ Blood Disorder ☐ Arthritis ☐ Cancer
☐ Hypertension ☐ Diabetes ☐ Heart Disease
☐ Chronic Back Pain ☐ Migraines ☐ Other _____

Guardian Information (if under 18 years old): **Legal Guardian:** ☐ **Y** ☐ **N**

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact (Nearest relative not living with you):

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SECTION 2

Are you currently covered by Medicaid? ☐ **Y** ☐ **N** **If yes, Medicaid/Card Number:** _____

Do you have: ☐ Medicaid ☐ Healthease ☐ Amerigroup ☐ Staywell ☐ United ☐ KidCare

Are you currently covered by Medicare? ☐ **Y** ☐ **N** **If yes, Card Number:** _____

Are you currently covered by any other insurance? ☐ **Y** ☐ **N** **If yes, Insurance Name:** _____

Policy #: _____ **Group #:** _____ **Deductible Amount:** _____

Insurance Co. Address: _____

SECTION 3

Total Number of Persons in Household (include unborn): _____

Total Earned Income for the Household (one month): _____
Before Deductions - (Wages, Salaries and Tips)

Total Unearned Income for the Household (one month): _____
(AFDC, VA, SSI, SSA, Contributions, Unemployment, Worker's Comp., Child Support)

Name of Business Where Employed: (1) _____ (2) _____

Phone Numbers of Employer: _____

_____ _____
SIGNATURE OF CLIENT or RESPONSIBLE PARTY **DATE**

_____ _____
EMPLOYEE SIGNATURE **DATE**

SECTION 4

PLEASE LIST ALL HOUSEHOLD MEMBERS

NAME	DOB	RELATIONSHIP	SSN	MEDICAID # OR MEDICARE #	INSURANCE COMPANY NAME	INSURANCE GROUP NUMBER