SILOAM HEALTH
MELROSE

Patient Demographics (Adults)

Patient's Last Name _____ First _____ Middle _____

Date of Birth (month) _____ (day) _____ (year) _____ Social Security Number _____-_____-_____

Current Street Address _____ Apt. # _____

City_____ State _____ Zip _____ County _____

Primary Phone _____ Secondary Phone _____

Work Phone _____ Ext. _____ Email address _____

The patient is a: ○ Male ○ Female

The patient is: ○ Married ○ Single ○ Divorced ○ Widowed ○ Other _____

If patient is married, name of wife or husband: _____

What is the patient's country of birth? _____

What is the patient's primary language? _____

Please mark the racial or ethnic group with which the patient identifies:

○ White (Caucasian, Middle Eastern, North African) ○ Latinx/ Hispanic ○ Asian
○ Black (African-American, African origins, Afro-Hispanics) ○ Multiracial
○ Native American/ Alaskan ○ Pacific Islander/ Hawaiian ○ Other

Is the patient currently working? ○ No ○ Yes If yes, where? _____

Does the patient have any Insurance or TennCare? ○ No ○ Yes (If yes, please show card to front desk.)

Who refers the patient to this clinic? _____

Other places where patient has received care: _____

X _____ / /

Signature of patient (Parent or guardian, if patient is under 18) **Today's Date**

Your signature on this form certifies this information is true and Siloam has permission to verify through other resources.

Sliding Fee Program

Fill this out to determine the office visit fee.

Please provide the following information for the patient and ALL FAMILY members living in the patient's house:

#	Names of all in the same household (Including patient)	Age	Sex (M or F)	A Patient at Siloam? (Yes or No)	Relationship to patient	Name of Employer	Monthly income from all jobs or other sources such as Social Security, Pensions, Investments, Child Support or Alimony	Name of Health Insurance Company
1								
2								
3								
4								
5								
6								
7								
						Total income →		