Patient's Information (Please print)

Name:_____
First *Middle* *Last*

❑ Male ❑ Female Race: _____ Date of Birth: _____/_____/_____

Address: _____

City: _____ Zip: _____

Phone (Include area code)

Preferred: _____ ❑Home ❑Cell ❑Work

Alternative: _____ ❑Home ❑Cell ❑Work

Primary Language: ❑ English ❑ Spanish ❑ Vietnamese ❑ Other: _____

Mother's Name _____
First *Last*

Father's Name:_____
First *Last*

Next of Kin/Guarantor Information ❑ **Same as above**

Name: _____

Relationship to patient: _____

Address: _____

City: _____ Zip: _____

Phone (Include area code)

Preferred: _____ ❑Home ❑Cell ❑Work

Emergency contact information ❑ **Same as above**

Emergency Contact Name:_____

Relationship to patient: _____

Preferred Phone: _____ ❑Home ❑Cell ❑Work

CHOC Children's

Dear Parents:

In order for CHOC Primary Care Clinics to continue to meet your child's healthcare needs, we are asking for your assistance in answering the following questions:

1. How many family members live in your home? _____

2. How much money does your family make before taxes? $ _____
   Per month

3. Source of family income (check one):
   - ☐ Earned
   - ☐ Disability
   - ☐ Retirement
   - ☐ General/public assistance
   - ☐ Other sources/unknown
   - ☐ None
   - ☐ Self-employment

4. Type of Employment (check one):
   - ☐ Executive/Professional
   - ☐ Production/Labor
   - ☐ Sales/Services
   - ☐ Farming/Forestry
   - ☐ Unemployed
   - ☐ Unknown
   - ☐ Self-employed

I certify that the information provided is true and accurate to the best of my knowledge. Further, I have or will apply for any assistance (Medi-Cal, Healthy Families, insurance, etc.) which may be available for payment of medical services. I will take any action reasonable necessary to obtain such assistance.
If I fail to comply with the referral process for identified programs this may result in not being considered for the financial assistance program.

Signature of guarantor_____ Relationship to Patient_____

FOR OFFICE USE ONLY:

Date of Visit _____ FPL_____ <100% FAP packet given ❑

CHOC Children's

Primary Care Clinics
FINANCIAL QUESTIONNAIRE

PATIENT ID