

Ozanam Charitable Pharmacy In Take Form Patient Intake Form

Applicant Name: _____
(Last) (First) (Middle initial)

Address: _____
(City) (State) (Zip code)

Date of Birth: ___/___/___ **Patient's SSN #** ___/___/___

Phone# Where you can be reached: _____

Place of Employment: _____ **Address:** _____

Medical Insurance Status

Check one:

Uninsured

Medicaid

Veterans (V.A)

Private Ins: _____

Medicare

Other : _____

Female Head of Household: ___ Yes ___ No **Number of Disabled Persons in Household:** _____

Is another member of your Household applying for Ozanam Charitable Pharmacy Services? ___ Yes ___ No **If yes, provide the name of person applying:** _____

DOB: ___/___/___ **Relationship** _____

*** Place a check by the series of questions below:**

Is this Ethnicity of this Head of Household Hispanic or Latino?
 Yes ___ No ___

White

Black/African American

Asian

American Indian/Alaskan Native

Native Hawaiian/Other Pacific Islander

Am. Indian/Alaskan Native and White

Asian and White

Am. Indian/Alaskan Native and Black

Other Multi-Racial

Marital Status	Gender	Homeless Status
<input type="radio"/> Single	<input type="radio"/> Female	<input type="radio"/> N/A
<input type="radio"/> Married	<input type="radio"/> Male	<input type="radio"/> Shelter
<input type="radio"/> Divorced		<input type="radio"/> Street
<input type="radio"/> Widowed		<input type="radio"/> Living with a friend or other

WHAT IS YOUR DOCTOR'S NAME, ADDRESS & PHONE NUMBER! WE MUST HAVE THIS! (USE THE BACK IF NEEDED)

Name _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Fax:** _____

DRUG Allergies? ___ YES ___ NO

If yes, please list: _____

IMPORTANT: (We must have proof of income for EVERYONE who lives in your household). Please attach proof of income (IRS 1040—if you filed taxes for the current year and /or Social Security Award letter and/or pay stub/ or food stamp letter.

SOURCES OF INCOME

TOTAL HOUSEHOLD MONTHLY INCOME: _____

___ Salary/Wages	___ Social Security Disability	___ Veteran's Benefits	___ Child support
___ Social Security	___ Workmen's Comp	___ Railroad Ret	___ Interest Income
___ Food Stamps	___ Pension		

FOR OFFICE USE ONLY:

Partner Agency: _____ Application Date ___/___/___

Caseworkers Name: _____

Caseworker Phone: _____

Patient Certification period: (circle one)

90 days 180 days 360 days 1x only