

HOKE MED ASSIST PATIENT ASSESSMENT

DATE: _____

First Name: _____ Middle _____ Last Name _____

Address: _____

City _____ State: _____ Zip _____

Home/Cell Phone: _____ Work Phone: _____

Gender: F – M; Birth Date: _____ Age: _____ Marital Status: S M D W

US Citizen Y or No; Race _____ Veteran Y or N; SSN _____

Declared Disabled by Social Security: _____ When did it begin?: _____

Do you have prescription coverage? Yes ___ No ___

Do you have insurance Coverage? Yes ___ No ___ if yes, what type of Insurance?

Do you smoke? Yes ___ No ___ If yes, are you interested in quitting? Yes ___ No ___

CAREGIVER/EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone Number: (____) _____

PHYSICIAN INFORMATION

Primary Care Physician's Name: _____

Phone#: _____ Fax#: _____

Name of Clinic: _____ Physician's Specialty: _____

Address: _____

City: _____ State: _____ Zipcode: _____

FINANCIAL INFORMATION

Total Household Income: \$ _____

Employed: _____ Employer _____

Work Type: _____

Number of Household Members over 18 yrs. _____ Under 18 yrs. _____

Name of each family member in household and relationship to you:

Name: _____ Relationship: _____

Monthly Income: _____ Sources of Income: _____

Name: _____ Relationship: _____

Monthly Income: _____ Sources of Income: _____

Name of each family member in household and relationship to you:

Name: _____ Relationship: _____

PROOF OF INCOME SOURCES:

Most Recent Tax Return: _____ No income letter from PCP: _____

Social Security 1099: _____ DSS or Food stamps form: _____

SS Award Letter: _____ Current Pay Voucher: _____

Unemployment Benefits: _____ Child Support: _____

