Space Coast Volunteers in Medicine

Patient Pre-Registration

Instructions

Please print legibly and complete all questions.

Patient Information

Legal First Name _____ Legal Last Name_____ Suffix ____

First Name Used _____ Middle Name _____

Previous Name (first, last) _____

Sex: Male Female (please circle one) Date of Birth _____ Social Security Number _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Mobile Phone _____ Ok to Text? ☐

Email Address _____

Language(s) _____ Decline to provide ☐

Race _____ Decline to provide ☐

Ethnicity _____ Decline to provide ☐

Family Information

For all amounts below, please answer using MONTHLY amounts.

Patient

Employer Name _____ Income Before Taxes & Deductions _____

Other Income (non-work) _____

Spouse / Partner

First Name _____ Last Name _____

Date of Birth _____

Employer Name _____ Income Before Taxes & Deductions _____

Other Income (non-work) _____

(Continued on other side)

Child 1

First Name _____ Last Name _____

Date of Birth _____ Fulltime Student? Yes No (circle one)

Employer Name _____ Income Before Taxes & Deductions _____

Other Income (non-work) _____ Child Support RECEIVED _____

Childcare PAID _____ Florida Medicaid ID Number _____

Child 2

First Name _____ Last Name _____

Date of Birth _____ Fulltime Student? Yes No (circle one)

Employer Name _____ Income Before Taxes & Deductions _____

Other Income (non-work) _____ Child Support RECEIVED _____

Childcare PAID _____ Florida Medicaid ID Number _____

Child 3

First Name _____ Last Name _____

Date of Birth _____ Fulltime Student? Yes No (circle one)

Employer Name _____ Income Before Taxes & Deductions _____

Other Income (non-work) _____ Child Support RECEIVED _____

Childcare PAID _____ Florida Medicaid ID Number _____

Child 4

First Name _____ Last Name _____

Date of Birth _____ Fulltime Student? Yes No (circle one)

Employer Name _____ Income Before Taxes & Deductions _____

Other Income (non-work) _____ Child Support RECEIVED _____

Childcare PAID _____ Florida Medicaid ID Number _____

Child 5

First Name _____ Last Name _____

Date of Birth _____ Fulltime Student? Yes No (circle one)

Employer Name _____ Income Before Taxes & Deductions _____

Other Income (non-work) _____ Child Support RECEIVED _____

Childcare PAID _____ Florida Medicaid ID Number _____