Teche Action Board, Inc.
Patient Profile/AZ&ME & Pfizer's STC Application

Account No._____ Medical Record No. _____ Location _____ Date:_____

A. PATIENT INFORMATION *(Please give receptionist your ID for copying)*

Patient Name _____ Date of Birth _____

Address_____ City _____ State _____ Zip Code _____

Home Phone No. _____ Work Ph# _____ Cell/Alternate Phone # _____

SSN# _____ Sex _____ Race _____ Are you a Veteran: Yes _____ No _____

B. EMERGENCY CONTACT INFORMATION

Please give the name of someone we can contact in case of an emergency (please list someone not living in the home with the patient).

Contact Name: _____ Relationship to patient: _____

Address: _____ Phone Number: _____

_____ Alternate Phone Number: _____

C. INCOME INFORMATION

Employer Name: _____ Employer's Address:_____

Employer Phone Number: _____ _____

Gross Income: _____ How often: _____

Spouse's Employer: _____ Employer's Address: _____

Employer Phone Number: _____ _____

Gross Income: _____ How often: _____

OTHER SOURCES OF INCOME

Do you Receive any of the following:

SSI _____ Veterans Assistance _____AFDC (Welfare) _____Child Support _____ _____
Amount Amount Amount Amount How Often

Social Security _____ Retirement Benefits _____ Are you receiving Food Stamps Yes ___ No ___
Amount Amount

D. INSURANCE INFORMATION *(please give your insurance card to the receptionist for copying)*

Do you have any type of insurance coverage such as Medicare, Medicaid, or Private Insurance: Yes ___ No ___

Insurance Company Name: _____ Policy Number: _____

Policy holder name: _____ Policy Holder DOB: _____ Policy Holder SSN: _____

Group Number: _____ Effective Date of Coverage _____

Medicare Number: _____ Medicaid Number: _____

E. HOUSEHOLD INFORMATION (please ask for additional paper if needed)

Name	Date of Birth	Sex	Relationship to Patient	Social Security Number	Race

F. CERTIFICATION

I certify that the information given on this form is true and accurate to the best of my knowledge. If the information given is proven false, I understand that Teche Action Board, Inc. can disqualify me for any discounts and bill me for all services received and any services paid by Teche Action Board, Inc. I also certify that I will report any changes in income or insurance status to Teche Action Clinic immediately. I understand that if I intentionally give false information, I can be disqualified from participating in the AZ&ME and Pfizer Program.

_____ _____

Signature of Patient or Guardian Date Signature of Interviewer Date

G. Acknowledgements

Please Initial the following:

I acknowledge that I have received a copy of the "patient rights and responsibilities" _____
I acknowledge that I have received the "patient information brochure" _____
I acknowledge that I have been given information on Living Wills and Advance Directives _____
I acknowledge I have received a copy of the "Speak Up" Brochure _____

H. Acknowledgement of Receipt of Notice of Privacy Practice

I, _____, have received the Notice of Privacy Practices from Teche Action Board, Inc.

_____ Date: _____

Patient, Parent or Guardian Signature

I. Please contact me as follows (check at least one):

___Home Telephone ( ) _____
___Leave message
___Leave message with call-back number on
___Do not leave message

___Work Telephone ( )_____
___Leave message with details
___Leave message with call-back number only
___Do not leave message

___Written Communication
___Mail to my home address
___Mail to my work address

Cell Phone No. _____

Alternate No. _____

J. AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION:

I hereby authorize Teche Action Clinic to release my records for review to AstraZeneca or its designee for audit purposes.

_____ _____

Signature of Patient or Guardian Date Signature of Interviewer Date