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

Account No	Medical Record No	Location	n	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: Y	es No					
B. EMERGENCY CONTA	CT INFORMATION								
Please give the name of someone	e we can contact in case of an emerger	ncy (please list someon	ne not living in the home wi	ith the patient).					
		Relationship to patient:							
2		Altamata Dhana Numban							
C. INCOME INFORMATION	ON								
Employer Name:		Employer's	Address:						
Employer Phone Number:									
Gross Income:		How often:							
Spouse's Employer:		Employer's	Address:						
Employer Phone Number:		2p.c.je. s		7.0					
Gross Income:		How often:							
OTHER SOURCES OF IN	COME								
Do you Receive any of the fo									
SSI Veterans	AssistanceAFDC	(Welfare)							
Amount	Amount	Amount	Amo						
Social Security Amount	Retirement Benefits Amou		you receiving Food Star	mps Yes No					
D. INSURANCE INFO	ORMATION (please give your ins	urance card to the r	eceptionist for copying)						
Insurance Company Name:			Policy Number:						
Policy holder name:	Pol								
Group Number:	Eff	Effective Date of Coverage							
Medicare Number		Medicaid Number							

	Name	Date of Birth	Sex	Relationship to Patient	Social Security Number	Race				
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F	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	Date					
G		Ac	knowledge	ments						
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										
 T	g and the state of									
1, _	, have received the Notice of Privacy Practices from Teche Action Board, Inc.									
I.	I. Please contact me as follows (check at least one):									
	Home Telephone ( ) Written CommunicationLeave messageLeave message with call-back number onMail to my work addressDo not leave message									
Leave message with call-back number only				0						
J.	I. AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION:									
	I hereby authorize Teche Action Clinic to release my records for review to AZ&ME, Pfizer, or any other patient program or its designee for audit purposes.									
-	Signature of Patient or C	buardian Date		Signature of In	terviewer Da	ite				

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