HealthNet ALBEMARLE | MEDICAL PHARMACY WELLNESS

918 Greenleaf Street
Elizabeth City NC 27909
252.248.3045

PATIENT INFORMATION

Please Print

First Name_____ MI_____ Last_____

Address_____City_____State_____ Zip_____

County_____ Home Phone_____ Cell Phone_____ Consent to text: ☐Yes ☐ No

Birthdate_____ Social Security Number_____

Sex: ☐Male ☐ Female Marital Status: ☐ Single ☐Married ☐ Legally Separated ☐Divorced ☐ Widowed

Race/Ethnicity: ☐ Black/African American ☐ White (not Hispanic or Latin) ☐ Hispanic or Latin
☐ Asian/Pacific Islander ☐ Native American ☐ Unknown

Are you a US citizen? ☐ Yes ☐ No Are you a Veteran? Yes ☐ No

Total # of people in the household (including children):_____ # of Children in the Household: _____

Please list all members that live in your household and income source (salary/wages, Social Security, Retirement, SSI, Unemployment, Food Stamps, Rental Income, Workman's Comp, Veteran's Benefits, etc):

Patient Name:_____ Monthly Income:_____ Income Source:_____

Name:_____ Monthly Income:_____ Income Source:_____
Birthdate_____ Relationship:_____

Name:_____ Monthly Income:_____ Income Source:_____
Birthdate_____ Relationship:_____

Name:_____ Monthly Income:_____ Income Source:_____
Birthdate_____ Relationship:_____

Do you have any type of medical or pharmacy insurance, including Medicaid, Medicare or Medicare Part D?

☐ Yes If so, name of insurance:_____ ☐ No

Have you applied for Medicaid? ☐ Yes ☐ No ☐ Pending

Are you currently employed? ☐ Yes ☐ No

Any known Drug allergies: ☐Sulfa ☐ Penicillin ☐ Codeine ☐Aspirin ☐ Erythromycin
☐Tetracycline ☐ No Drug Allergies ☐Other:_____

Do you want to enroll with the HealthNet Albemarle (HNA) patient portal? ☐ Yes ☐ No

If yes, please provide your email:_____

How did you hear about us? _____

Fraud Warning:
You have requested services from HNA. This clinic provides health care and prescriptions to qualifying individuals. By signing this form you attest that the information you have given is a true and complete statement of facts. Any questions answered incorrectly whether they are misunderstood or intentionally falsified may constitute fraud. Committing fraud will prevent you from receiving future health care and prescriptions through HNA and will result in your being responsible for payment of fees.

Patient Signature:_____ Date:_____