Discounted/Sliding Fee Application

Patient Information			**Today's Date: / /**	
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Cell Phone #: ( ) -		
Date of Birth: / /	Social Security # - -		Do you have insurance? (circle one) Yes No	

Household Members	**Place of Employment**	**Household Income**	
Name	**Company**	**Annual**	**Monthly**

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program. I further agree to inform Premier Pediatrics if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Premier Pediatrics. I hereby acknowledge that I read the foregoing disclosure and understand it.

Name: _____

Date:_____

Signature: _____

Office Use Only

Patient Name: Discount:

Date of service: Approved By: