VIRTUAL CLINIC INTAKE FORM

Today's Date:_____

Applicant Name:_____

Birth Date:_____Age:_____Gender: **M** **F** Email Address:_____

Home Address (no PO box):_____

Home Phone:_____ Cell Phone: _____ Email: _____

Spouse's Name: _____

Patient's Name (if different from applicant):_____ Relationship to Applicant:_____

*If you are seeking a free medical consultation with one of our clinicians or specialists, please complete this application in its entirety. If you are seeking a timely appointment with a specialist and will be paying cash and/or using private insurance, please proceed to the asterisk (*) on page 3.*

Monthly Income	**Applicant**	**Spouse**
Income from Employment (after taxes)	$	$
Income from Operating Business	$	$
Other Income:_____	$	$
Interest & Dividends	$	$
Real Estate and Property Income	$	$
Social Security Benefit Income	$	$
Disability Income	$	$
Alimony, Child Support Income	$	$
Total Monthly Income	$	$

If income is $0 / Unemployed, what are your means of support?

__ Living on savings
__ Live with friends (must submit signed letter of support to prove)
__ Parental or familial support, please specify: _____
__ Homeless
__ Shelter

Monthly Expenses	
Rent or mortgage payment	**$**
Automobile payment	**$**
Credit Card payment	**$**
Insurance Payments	**$**
Groceries, household expenses, utilities	**$**
Tuition payment	**$**
Other (please specify) _____	**$**
TOTAL	**$**

Credit Card Debt: Please list all credit cards and the balance owing, continue on a separate sheet if needed	
	$
	$
	$
	$
	$
TOTAL	**$**

Personal Debt: Please list all personal loans obtained from family and friends and the balance owing, continue on a separate sheet if needed	
	$
	$
	$
	$
	$
TOTAL	**$**

If your monthly expenses exceed your income, how do you cover the difference?

_____

Total number of people in your household (include yourself): _____ Do you own your home: **Yes** **No**

How many vehicles do you own/finance: _____ lease: _____ Please list the make, model and year of all your vehicles:

_____

_____

***** Do you have Medi-Cal? **Yes** **No** Medicare? **Yes** **No** Private health insurance? **Yes** *(see below)* **No**

Name of private insurer and policy details:_____

Are you seeking a first opinion? **Yes** **No** Second opinion? **Yes** **No**

Please briefly describe the illness, injury and/or symptoms you are seeking a consultation for: _____

_____

_____

_____

_____

What type of physician/specialist are you looking to meet with? _____

What is your purpose/goal for this consultation? _____

_____

_____

I _____ understand that upon completion & submission of this form a representative of Ateres Avigail will review the information herein in order to determine whether assistance can be provided, submission of this form is not a guarantee of service. If necessary, further information may be requested. Ateres Avigail reserves the right to refuse service and/or terminate assistance at any time.

I _____ certify that the information I have provided on this form is accurate and true. I also certify that this information may be shared with others for the purposes of rendering aid.

Applicant's Signature:_____Name:_____Date:_____

Name of person completing this form *(if different from applicant):*_____

Signature:_____ Relationship to applicant:_____Phone:_____

PLEASE RETURN COMPLETED FORM VIA ONE OF THE FOLLOWING METHODS:

EMAIL INFO@ATERESAVIGAIL.ORG / FAX 323.544.6067 / MAIL 5967 W. THIRD ST. STE #340 LOS ANGELES, CA 90036

THANK YOU