Patient Name: _____

DOB: ____/____/____

Carolina Fellows Family Dentistry

A Granville Vance Public Health Facility

Types of income:

- ☐ Salaries, wages, overtime pay, commissions, fees tips
- ☐ Earnings from self employment
- ☐ Interest earned on investments
- ☐ Public assistance
- ☐ Unemployment compensation
- ☐ Allowances paid for basic living expenses
- ☐ Educational stipends in excess of the cost of tuition and books
- ☐ Regular contributions from individuals not living in the household
- ☐ All other sources of cash income except those specifically excluded
- ☐ Supplemental Security Income (SSI)
- ☐ Disability
- ☐ Other (specify):_____
- ☐ Worker's compensation
- ☐ Alimony and/or child support
- ☐ Social Security benefits
- ☐ Retirement and pension payments
- ☐ Veteran's Administration benefits
- ☐ Prize winnings
- ☐ Bank statements
- ☐ Dividends

Name(s)	Employer/ Source of Income	Gross Income Weekly *(multiply by 52)* Bi-Weekly *(multiply by 26)* Bi-Monthly *(multiply by 24)* Monthly *(multiply by 12)*	Gross Annual Income

Total Income: $_____ **Total in household: _____**

Name (Child 1): _____ *Name (Child 2):* _____

Name (Child 3): _____ *Name (Child 4):* _____

Name (Child 5): _____ *Name (Child 6):* _____

☐ ***Proof of income has been provided and I understand that I am fully obligated for payment of fees for services provided at _____%.***

☐ ***Proof of Income has not been provided, patient/guardian states annual household income is $_____. I understand that I am fully obligated for payment of fees for services provided at _____%.***

I verify the above information is true to the best of my knowledge and I understand payment is expected at the time service for all services rendered. **Please note that the Sliding Fee Scale discounts do not apply to lab fees, the patient is responsible for 100% of the lab fee.**

Signature of Patient/Parent/Legal Guardian: _____ Date: _____

Relationship to Patient: _____

Staff Initials: _____