Psychiatric & Psychological Specialties
Great Lakes Sports Medicine & Concussion Clinic

Name of Head of Household | Place of Employment

Street | City | State | Zip | Phone

Health Insurance Plan | Social Security Number

Please List spouse and dependents under age 18

Your Name | Date of Birth

Spouse's Name | Date of Birth

Dependent's Name | Date of Birth

Dependent's Name | Date of Birth

Dependent's Name | Date of Birth

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self-employment and dependents				
Rent, interest, dividend, and other income				
Total Income				

Verification Checklist

Income: Prior year tax return, three most recent pay stubs, or other. ☐ Yes ☐ No
Insurance: Insurance card(s) ☐ Yes ☐ No

I certify that the information shown above is correct and understand verification is required for approval.

_________________________________ _________________________________
Name (Print) Signature/Date

Office Use Only

Pay class approved: _______________________ Effective date: _________________________

Approved by: ____________________________ Expiration date: ________________________