



Non Profit 501c3
1640 Fort St. Suite E
MI 48183

www.ziadhealthcare.org
313-815-8767 Trenton,
Fax: 810-458-4187

PARTICIPANT INTAKE FORM

Name: _____

Address: _____

City: _____ Zip: _____

Telephone: _____

Social Security Number: _____

Date of Birth: _____

Employer: _____

Annual Salary: _____

Number of Dependents living with you: _____

Total income for all sources: _____

Are you insured: _____

If so, what insurance: _____

(Insured PARTICIPANTs are not eligible.)

Race: _____

(Not required, statistical purpose only)

I understand that I am applying to receive a discounted service from the doctor's office that has presented me with this form. The doctor's office, solely, will determine my eligibility for this program. I agree to have my data shared with Z.I.A.D. healthcare for the Underserved, Inc. whom may in turn use this data to apply for future funds to cover under/uninsured populations with health care. I hereby release this information and any medical information to them.

PARTICIPANT's Signature
(Parent's signature if PARTICIPANT is under 18 years old.)

Date

Provider's Office where form is being used:

Physician Name

Physician Address