Patient Application

☐ New ☐ Update

Today's Date: ________________ **Have you received services from the Free Clinic in the past?** ☐ **Yes** ☐ **No**

Services Requested: ☐ **Medical** ☐ **Dental** ☐ **Pharmacy** ☐ **MedsHelp**

Last Name: ____________________________ **First Name: ____________________** **Middle Initial __________**

Date of Birth: ______/________/_______ Age: _________ Social Security Number: __________________

Mailing Address: ____________________________ City: _________________________ ZIP: ____________

Home Address: _____________________________ City: _________________________ ZIP: ____________

County of Residence: ________________________ Email Address: _____________________@______________

Phone Home: ________________________ Work: _________________ Cell: __________________________

Please initial if you authorize us to leave a detailed message with health information on your voice mail: _________

Emergency Contact:

Last Name: ____________________________ First Name: _________________ Relationship: ________________

Phone Home: ________________________ Work: _________________ Cell: __________________________

Please initial if you authorize us to share medical information with your emergency contact: ___________________

Health Insurance:

I have the following insurance (check all that apply): ☐ **Health** ☐ **Dental** ☐ **Prescriptions** ☐ **None**

Please indicate the type of insurance:

☐ **Medicaid** ☐ **Medicare A** ☐ **Medicare A& B** ☐ **Veteran's Assistance** ☐ **Private Insurance**

Name of Doctors that you are seeing now or in the past 3 years:

Name: ____________________________ City: _________________ State: ________ Phone: _________________

Name: ____________________________ City: _________________ State: ________ Phone: _________________

Have you been to the Emergency Room in the past year: ☐ **Yes** ☐ **No** If yes, when? ________________

FOR OFFICE USE ONLY – CHANGE OF CONTACT INFORMATION

Mailing Address: ____________________ City: ___________________ ZIP: _________ Date of Change: _________

Phone Home: ___________________ Work: _________________ Cell: ___________ Date of Change: _________

Phone Home: ___________________ Work: _________________ Cell: ___________ Date of Change: _________

Demographic Information:

Gender: ☐ **Male** ☐ **Female** ☐ **Transgender**

Race: ☐ **African American** ☐ **American or Alaska Native** ☐ **Asian**

☐ **Caucasian** ☐ **Native Hawaiian or Pacific Islander**

☐ **Other** ________________________________

Do you consider yourself to be Hispanic or Latino (a person of Mexican, Puerto Rican, Cuban, Central American, South American, or other Spanish culture or origin, regardless of race)?

☐ **Yes** ☐ **No**

Marital Status:

☐ **Married** ☐ **Not Married**

Employment Status:

☐ **Employed** ☐ **Not Employed**

If employed, does your employer provide health insurance to employees?

☐ **Yes, and I am eligible** ☐ **Yes, but I am not eligible** ☐ **I don't know** ☐ **Not applicable**

Veteran Status:

☐ **Veteran** ☐ **Not a Veteran**

I certify that the information I have provided is true and accurate according to the best of my knowledge. I agree to report any changes in insurance status or changes in income which bring me over 200% of the Federal Poverty Level within 7 days of the change. I understand that if I give false information or withhold information I will no longer be eligible for services from the Free Clinic.

I understand that it is my responsibility to provide documentation and update my eligibility annually.

As a Free Clinic or MedsHelp patient, I give my permission to the staff of the Free Clinic to release verification of my Eligibility/Household Income to any Medical Practice, Pharmaceutical Company, Rx Partnership, Pharmacy Connection and/or Centra Health that may be providing me with medical care, medications or other services, in order to determine eligibility for reduced fee or no fee services or medications, and for auditing purposes.

____ ________________

Patient Signature Print Name Date

____ ________________

Screening Staff Signature Print Name Date

FOR OFFICE USE ONLY

Eligibility Date: ________________ Income Level: ☐ 0 – 100% ☐ 101% - 138% ☐ 139% - 200%