FreeClinic
OF CENTRAL VIRGINIA

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 State 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 of 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 the 250% 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 Heath 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 _____

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Eligibility Date _____ Income Level ☐ 0 - 100% ☐ 101% - 138% ☐ 139% - 200%

Submit