Name: ____

Address: ____

City: ____________________ State: _______ Zip Code: _______________ County: _________________

Home Phone #: (______) ____________________________ Cell Phone #: (_______) ______________________

Work Phone #: (______) ____________________________ Other Phone #: (______) ______________________

May we leave medical information on your answering machine or voicemail?: _________*Yes* ________*No*

Email address: ____

Emergency Contact: Name: ______________________________ Phone Number: ______________________

Relationship to You: ___________________ Can we leave a message with this person?: ______ Yes______No

Are you currently employed? *(circle one):*

Full Time Part Time Self Employed Retired Unemployed Student Disabled

If employed, where: _________________________ If unemployed, when were you last employed?: __________

Date of Birth: _________________________ Social Security Number: _________- ___________ - ___________

Race/Ethnicity: ____________________________________ Circle One: Male Female

Are you married? *(circle one):* Married Single Legally Separated Divorced Widowed

Number of children: ________ Total number of <u>people</u> living in your household/place of residence: ___________

Are you the head of the household (when filing taxes)? ______ Yes ______No

Are you a veteran? ________ Yes ______No *If yes- are you eligible for VA Benefits?*_____ Yes _____No

How far did you go in school?______________________________

Your primary language *(circle one):* English Spanish Other (specify):__________________

Health Insurance? *(circle one):* No insurance Medicare Medicaid Private Insurance

Have you been denied for Medicaid? ______ Yes _____ No If yes, when? _____________________

Are you allergic to any medications? *(if so, please list name and reaction)*: ______________________________

____

Current Medications you are taking:

1. ______________________________ 4. ______________________________
2. ______________________________ 5. ______________________________
3. ______________________________ 6. ______________________________

Vitamins/Herbal Supplements *(please list)*: ____

Past Surgeries *(please list, along with year and hospital)*:____

____

Revised 12/07/10

Today's Date: _____________________

Family History:

Father:	Living/Deceased	Age ________	Specify Illnesses____________________________
Mother:	Living/Deceased	Age ________	Specify Illnesses____________________________
Brother:	Living/Deceased	Age ________	Specify Illnesses____________________________
Sister:	Living/Deceased	Age ________	Specify Illnesses____________________________
Other:	Living/Deceased	Age ________	Specify Illnesses____________________________

Have *YOU* had:			**Explain:**
Anemia	Yes	No	________________________
Arthritis	Yes	No	________________________
Asthma	Yes	No	________________________
Bleeding tendencies	Yes	No	________________________
Bowel disease	Yes	No	________________________
Cancer	Yes	No	________________________
Cholesterol problems	Yes	No	________________________
Depression/Anxiety	Yes	No	________________________
Diabetes, Type I	Yes	No	________________________
Diabetes, Type II	Yes	No	________________________
Epilepsy	Yes	No	________________________
Eye disease	Yes	No	________________________
Gout	Yes	No	________________________
Heart Disease	Yes	No	________________________
Heartburn(frequent)/Ulcer	Yes	No	________________________
Liver Disease	Yes	No	________________________
High Blood Pressure	Yes	No	________________________
Kidney Disease	Yes	No	________________________
Major Blood Vessel Disease	Yes	No	________________________
Migraines	Yes	No	________________________
Neurological Disease	Yes	No	________________________
Osteoporosis	Yes	No	________________________
Lung disease	Yes	No	________________________
Stroke	Yes	No	________________________
Thyroid Condition	Yes	No	________________________
Transfusion	Yes	No	________________________

Do you smoke? _______ Yes _______No _______ Quit Quit date:________________________

Number of packs per day: _________ Years Smoking:__________________

Do you chew tobacco? _______ Yes _______No _______ Quit Quit date:_________________

Do you drink alcohol? _______ Yes _______No Drinks per week:_______Quit date:_______________

Have you used illegal drugs? _______ Yes ______No ______Quit Specify: ________________________

Do you exercise: __________ Yes ______No Number of times per week: ________________

Do you drink caffeine: ____________ Yes ______No Number of drinks per day: ________________

Revised 12/07/10

Today's Date: ______________________

Shared Care Free Clinic Eligibility Form

This information is confidential and will only be used to calculate eligibility for medications and services.

You need to provide documentation of your income (most recent tax filing, W2, Last 4 pay stubs, disability letter, social security letter, unemployment benefit letter, pension benefit letter, etc)

Patient Name ____
Today's Date __________________

The following must be completed for everyone living in the household.

Please list specific dollar amounts for each category:

MONTHLY INCOME	**Self**	**Household Member**	**Household Member**
Salary and Wages			
Child Support			
Social Security Retirement			
Social Security Disability			
SSI			
Retirement			
Pension Payments			
Unemployment			
Food Stamps			
Rental Income			
Workman's Compensation			
Veteran's Benefit			
Investment Income			
Other			

Household Members with income:

Name ___________________________________ Relationship _________________________
Name ___________________________________ Relationship _________________________
Name ___________________________________ Relationship _________________________

Dependents

Name ____ Age________________
Name ____ Age________________
Name ____ Age________________
Name ____ Age________________

Do you currently have Medicaid?__________ Medicare?_______Health Insurance?____

I agree that I have provided truthful information about my finances.

Signature____ *(Revised 12/07/10)*

Revised 12/07/10 **Today's Date: ____________________**

The Shared Care Free Clinic of Jackson County is here to serve patients who have no insurance, have a chronic illness and who have a household income of less than 200% of the Federal Poverty Level. The clinic volunteers work hard to be sure that patients are treated with kindness and respect and are provided high quality care.

As a patient of the SCFC, I am entitled to

- Courteous and kind treatment
- Information about my condition
- Ask questions at any time
- Understand my medication and lab results
- Be an equal partner in my care
- Respect for cultural, psychosocial, spiritual, and personal values beliefs and preferences

As a patient of the SCFC, I agree to

- Let the clinic know if I have a change in my health or medications
- Let the clinic personnel know if I have an increase in income or acquire some kind of insurance including Medicaid or Medicare
- Let the clinic know if I have a change in address or phone number
- Keep my appointments unless I call ahead to cancel
- Provide the necessary paperwork as requested each year
- Treat the volunteers and staff courteously
- Work hard in caring for myself

The clinic does not charge for services but requests donations when you are able to do so. If you are able to purchase your own low cost medications, please advise the clinic personnel.

The clinic provides limited services. The clinic has the right to end care if the medical condition is more complex than the clinic resources can manage. Referrals to alternative resources will be provided.

The clinic has the right to end care if the patient cannot be provided quality services either because of behavior or failure to participate in the care plan.

The clinic has the right to end care if the patient fails to show for 3 appointments without calling.

The patient always has the right to seek health care services elsewhere and records will be provided upon request. The Shared Care Free Clinic is not responsible for charges from outside of the clinic.

I agree to treatment by the volunteers and staff of the Shared Care Free Clinic including their employees, agents designees and professional consultants. I understand that my protected health information is private. The clinic agrees to safeguard that information. The clinic will release that information on written request from the patient. Information about substance use or mental health needs is treated with particular care. The information however can be used to perform quality of care evaluation or for grant reporting. The clinic will release the information if appropriate legal authorities request it. I am aware that the practice of medicine is not an exact science and I have been provided no guarantees as the result of examinations, treatments or procedures.

I have read this form carefully and agree to its content.

Printed Name ____ Date _______________

Signature____

Revised 12/07/10

Today's Date: ___________________