PATIENT INFORMATION SHEET

ID#______
EMR ______
E File ____

Please circle one:
New Patient or Update or Info change

Demographics

First Name:__________________ **Middle:**_______________ **Last:**_____________________ **DOB:**____/___/______

SS#___________/______________/__________ **Photo I.D. provided:** ______**Yes** ______**No**

Address: *(Street)*___________________________ *(City)*_______________ *(State)*________ *(Zip)* _______________

*(County)*___________________**Preferred way to contact you:** ***Home Phone / Work Phone / Cell Phone / E-Mail***

Number/s we can leave a message: Home#:__________________ Cell #:_________________Work#:_____________

E-Mail Address : _____________________ **Sex:** _______**Race:**_______________ **Ethnicity:** _________________

Veteran _______ **U.S. Citizen** _________ **US Resident** ________ **Head of Household** __________

Marital Status: Single Married Separated Divorced Widowed **Number of Children** ______ **Number in Family**_____

Emergency Contact: ______________________________ **Relationship:**____________ **Phone #:**_______________

Proof of Residency: Driver's License/ Government Issued Photo ID with address/ Current Utility bill

If you reside with someone else, please provide a written statement from them that you live in their household and supply a postal mailing you received which shows your name and address on it.

Household Size (including yourself): _______ **FAMILY PHYSICIAN**:_____________________________________

HOW DID YOU LEARN ABOUT THE FREE CLINIC?____

Do you have any of the following:	**YES**	**NO**
Veteran's Assistance	____	___
Medicaid/Access Card/Medicare	____	___
Other health insurance	____	___
Worker's Comp Health Coverage	____	___

*Specify WC injuries*______________________________________

Proof of Medical Assistance Denial:
___**Yes** or ___**No**

Medical Assistance Denial Letter Dated:
____

Are you a college student? If yes, are you listed as a dependent on your parent's income tax return? ___**Yes** or ___**No**
Do you have health coverage under your parent's health plan? ___**Yes** or ___**No**
Does your school include health benefits as part of your tuitions? ___**Yes** or ___**No**

CURRENT EMPLOYMENT INFORMATION

Spouse's Name_______________________________

	Patient	**Additional Employment**	**Spouse**
Occupation/Dependent:	____________________	________________________	______________________
Employer:	____________________	________________________	______________________
Employer Address:	____________________	________________________	______________________
Phone #:	____________________	________________________	______________________
FULL/PART TIME:	_____/HR _____ /WK	F / P TIME:_____/HR _____/WK	F / P TIME:_____/HR _____/WK

I understand that the above information is correct to the best of my knowledge and <u>it is my responsibility</u> to inform the staff of any changes. I understand the above information may be verified and further documentation may be required.

______________________________________ ______________________________________
Patient Signature *Date* ***Screener's Signature*** *Date*

Revised:5/2015

STOP
This section to be completed by FMC Evaluator

PATIENT FINANCIAL FORM

Please circle one **(Initial** or **Recertification)**

Name: ______________________________ DOB:____-____-____
(Last) (First) (Middle)

EMPLOYMENT/INCOME DOCUMENTS

Pay Stub ____________

1040 ____________

Schedule C, if self-employed____________

Income Determination Letter____________

Unemployment____________

Non-filer 4506____________

Employer Letter____________

Direct Deposit Bank Statement________

CURRENT MONTHLY FINANCIAL INFORMATION: # of Dependents claimed on your tax form (minimum, self (1)):___

	Patient	***Spouse***	***Totals***
Wages/salary:	$____________	$____________	$________
Unemployment compensation:	$____________	$____________	$________
Date last day of employment	____________	____________	
Disability:	$____________	$____________	$________
SSI:	$____________	$____________	$________
Veteran's Benefits:	$____________	$____________	$________
Pension/Retirement:	$____________	$____________	$________
Child Support:	$____________	$____________	$________
Alimony:	$____________	$____________	$________
Other: (Specify)____________		$____________	$________
CURRENT MONTHLY TOTALS:	$____________	$____________	$________

*** TOTAL (CURRENT) ANNUAL HOUSEHOLD INCOME: * $ ____________**

(Please remember to exclude lost income from prior employment, if applicable)

COMMENTS/NOTES:____

____

PRIOR YEAR 1040, (Specify Year)____________ **ANNUAL INCOME:** $____________

Screener MUST complete

DETERMINATION:____

* ***Fed Poverty Cat. (Please circle one that applies):*** *1) up to 100%* *2) 101% - 200%* *3) 201% - 300%*

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