



Patient Registration Form

First Name _____ MI _____ Last Name _____

Social Security # _____ - _____ - _____

Address _____ Address 2 _____
City _____ State _____ Zip _____ County (Augusta)

Employment Status _____ Home Phone (____) _____
(Full Time/Part-Time/ Unemployed/ Retired/ Student/ Child/ Disabled) Work Phone (____) _____

Race _____ Sex _____ Marital Status _____ Date of Birth _____
(single, married, legally separated, divorced, widowed)

Number in Household (Self, Spouse, Children) _____

Veteran _____ U.S. Citizen _____ Insurance _____
(Y/N) (Y/N) (Medicare/Medicaid/Other/Uninsured)

Year of Most Recent Tax Return Filed 200__ _____ Education Level _____
(Less than High School, High School Graduate, Assoc Degree, 4 Yr College Degree)

Language: English () Spanish () Other () _____

Emergency Contact Information:

Contact Name _____ Relationship _____
Work Phone (____) _____ Home Phone (____) _____
Email (optional) _____

Patient Employer Information:

Current or Last Employer _____
Address _____
City _____ State _____ Zip _____
Phone _____ Start Date _____ End Date _____

PATIENT MEDICAL HISTORY

Patient Name: _____

Please check all that apply

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Major Blood Vessel Disease |
| <input type="checkbox"/> Anticoagulation | <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Multiple Sclerosis or |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nerve Disease (e.g. Parkinson's) |
| <input type="checkbox"/> Asthma/COPD | <input type="checkbox"/> GERD | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Gout | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Blood/Plasma Transfusion | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Bowel Disease | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Transfusions |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Kidney Disease | |

Infectious Diseases

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Parasite Infection | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease (Type) _____ |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever | |

Current Meds/Dosage

Current meds & dosage here:

Other Medical Conditions

List any other medical conditions here:

- Artificial Heart Valve
- Artificial Joint
- Emphysema
- Heart Murmur
- Pacemaker
- Mitral Valve Prolapse
- Nervous Problem
- Shortness of Breath
- Pregnant
- Other

Notes

Any notes for this patient's medical history

Allergies

Allergy _____ Effect _____

Date of Onset _____

Allergy _____ Effect _____

Date of Onset _____

Other Types of Allergies _____

Patient Signature	Date	Nurse Signature	Date
-------------------	------	-----------------	------

CONSENT FOR TREATMENT

By requesting care in the Free Clinic, I am giving the volunteer health provider and staff permission to examine, diagnose and treat me. I understand that all the health professionals at the Free Clinic are appropriately licensed and will observe accepted professional standards of care. I understand that all licensed health care professionals, whose name and license numbers are on file with the VA Department of Risk Management, are immune from professional liability while providing services as a volunteer.

(Initials)

NOTICE OF DEEMED CONSENT

Sections 32.1-45.1 of The Virginia Code authorizes health care providers to test patients for HIV and Hepatitis B & C when providers or someone employed by/under direction or control of provider is exposed to bodily fluids of the patient in a manner which, according to current guidelines of the Center for Disease Control, may transmit HIV or Hepatitis B or C viruses. In the event of such an exposure, I am deemed to have consented to testing and release of results to person(s) exposed. HOWEVER, I will be counseled before any of my blood is tested for HIV or Hepatitis B or C, as well as afterwards when I receive the results.

(Initials)

RELEASE OF INFORMATION

I give permission for the Augusta Regional Free Clinic to access information concerning my prior care at Augusta Medical Center or from other providers, if deemed necessary for current treatment. I also give the Augusta Regional Free Clinic permission to release medical records and information for following (Circle Yes or No).

YES / NO : Referral Doctors, Dentists, Specialists and Hospital _____
(Initials)

YES / NO : Family / Friends _____
(Names of Family/Friends To Whom We May Release Information) _____
(Initials)

YES / NO : Health Care Product Suppliers, Pharmaceutical Companies, RxPartnership, and /or the Every Woman’s Life Program as appropriate for reduced and/or no-cost programs. These programs may also require tax information. _____
(Initials)

YES / NO : I give my permission to the Augusta Regional Free Clinic to sign my name to application forms of pharmaceutical companies in order to apply for medications prescribed for me from their indigent care drug programs. _____
(Initials)

These permissions may be cancelled in writing by me at any time, but otherwise, are in effect while I am a patient of the Free Clinic. By signing and initialing this form I am certifying that I understand the meaning of the above statements.

Signature of Patient or Parent/Guardian

Date

<u>Name</u>			<u>SS#</u>
Patient Income Data:			
<u>Monthly Income</u>	<u>Patient</u>		<u>Spouse**</u>
Salary/Wages	\$ _____		\$ _____
Child Support*	_____		Checking _____
Social Sec Retirement	_____		Savings _____
Social Sec Disability*	_____		CD/ETC _____
SSI*	_____		IRA _____
Retirement/Pension	_____		
Unemployment	_____		OTHER INFO SCREEN
Food Stamps	_____		***Tax Return Rec'd
Rental Income	_____		December 31, 20__
Workman's Comp	_____		***4506 Rec'd
Veteran's Benefits	_____		December 31, 20__
Investments	_____		
Other	_____		Monthly Total \$ _____

(*Include Payments for Children in Patient's Income if Applicable)

Spouse Information:

Name _____
Sex _____ DOB _____ Employed _____
(Y/N)

(**Data Entry Note: If Spouse Income Information is provided – Input Data in Household Members Screen)

The information I have given is correct to the best of my knowledge. I agree to notify the Augusta Regional Free Clinic of any changes in my financial situation and provide up to date contact information. I also certify that I do not have any type of medical insurance. I understand that I must provide proof of income to be eligible for the medical services provided at the clinic and to be referred for other specialty medical services.

I acknowledge receipt of the AMC financial assistance application and understand it is my responsibility to complete the application process as soon as possible. I further acknowledge that receipt of financial assistance from AMC is required for referral to some specialty practices.

Signature of Patient or Parent/Guardian Date _____

Signature of Free Clinic Representative Date _____

___ Patient Ineligible-DATA ENTRY PLEASE NOTE AS SUCH IN PATIENT DETAIL SCREEN

Disability Form

As a patient of the Augusta Regional Free Clinic:

- I am not on disability
- I am not applying for disability
- I do not plan to apply for disability

If this should change, I will notify the clinic immediately. I understand that applying for or being on disability makes me ineligible for clinic services. I understand that services are provided by volunteer health providers who give of their free time to see patients, and that paperwork for disability would take them away from family time.

_____	_____	Date
Name	_____	Date
	_____	Date
	_____	Date
	_____	Date
	_____	Date
	_____	Date
	_____	Date
	_____	Date
	_____	Date

AUGUSTA REGIONAL FREE CLINIC NEW PATIENT SURVEY

Date_____

1. How did you find out about the Augusta Regional Free Clinic?

Family Friend Free Dental Clinic Health Department Hospital
 Newspaper Social Services Other

2. Why did you choose to come to the Augusta Regional Free Clinic?

Could not afford regular medical providers
 Have no regular medical provider
 Could not afford prescriptions
 Evening hours
 Other: _____

3. What would you have done if the Augusta Regional Free Clinic were not here?

Would not have gone to the doctor
 Would have gone to the emergency room
 Would have tried to get the money to see a regular medical provider

4. When did you last see a doctor? Approximate date: _____

5. How many times in the past 12 months have you been seen in the Emergency Room?

Never 1 time 2-5 times 6-10 times 11 or more times

6. I am: Male Female

7. Age: 18-24____ 25-34____ 35-44____ 45-54____ 55+____

8. Race: African Am. Asian Latino/Hispanic Native Am.
 White Other

9. Employment Status: Full Time Part Time Unemployed Retired
 Disabled Full Time student

10. Highest Education Attained: Some high school
 High School Diploma/GED
 Some College
 Two-Year Degree/Professional Degree
 Four-Year Degree
 More than Four-Year Degree

11. Is getting transportation to the Augusta Regional Free Clinic a problem for you?

Y N

12. How do you plan to get to the Augusta Regional Free Clinic for your next appointment?

Family Member Friend Own Transportation Taxi
 Public Transportation Other: _____

V03/27/2007