



## 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 \_\_\_\_\_

Date of Onset \_\_\_\_\_

Effect \_\_\_\_\_

Allergy \_\_\_\_\_

Date of Onset \_\_\_\_\_

Effect \_\_\_\_\_

Other Types of Allergies \_\_\_\_\_

**Female Patients**

Information on Most Recent Pap Smear

**Date (If Known)** \_\_\_\_\_

**Location** \_\_\_\_\_

(Health Department, Private Physician)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Nurse Signature      Date



<u>Name</u>		<u>SS#</u>	
<b>Patient Income Data:</b>			
<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	_____	_____	<b><u>OTHER INFO SCREEN</u></b>
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 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.

\_\_\_\_\_  
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