The Free Medical Clinic Patient Registration Information Form

Please provide the following information (<u>front and back</u>) as we prepare for your care (Please print):

Full Name:

Date of Birth:
Social Security Number:
Street Address:

City:
Zip Code:
County of Residence: Anderson / Morgan / Roane
Home/Mobile Phone Numbers
Email Address:
Contact Preference (Circle one) **Email / Phone**
I was referred by:

Primary Language:
Race:
Ethnicity:
Marital Status:
Level of Education:

Date:
Sex: Male / Female
Do you have medical insurance? Yes/No
Smoker? Yes/No
Tobacco user? Yes/No
Drink alcohol? Yes/No
Homebound? Yes/No
Transfer from Hospital? Yes/No
Medical & Meds History Authorized? Yes/No
Weight:
Height:

If Employed (Employer name, phone number):
Job Title:
How long have you worked in this position?
Where do you fall in the following Household Income Information? (Check one)
☐Single $24,980 or less ☐Family of two $33,820 or less ☐Family of three $42,660 or less
☐Family of four $51,500 or less ☐Family of five $60,340 or less ☐Other:

Emergency Contact (Name, relationship, phone number):

Pharmacy Information and Preferred Pharmacy (Name and phone number):

"To the best of my knowledge this information is complete and accurate." **(Please sign below)**

Signature:
(or) Guardian Name and Signature:

Office use only:
☐ Approved Resident/Program ☐No Insurance ☐Meets Income Requirements

PAST MEDICAL HISTORY
(Check any conditions you have had)

___Acid Reflux (GERD)
___ADHD
___AIDS/HIV
___Anemia
___Anxiety
___Arthritis
___Asthma
___Bladder problems
___Blood Diseases
___Blood Transfusion
___Breast Problems
___COPD
___Cancer
___Constipation
___Coronary Artery Disease
___Muscle/joint/bone
___Depression
___Development Disorders
___Polyps
___Difficulty Swallowing
___Pre-eclampsia
___Diverticulitis
___Eating Disorders
___Eczema
___Endometriosis
___Osteoporosis
___Other: (please explain):

___Headaches
___Heart Disease
___Hepatitis
___ Hospitalizations
___High Cholesterol
___High Blood Pres. (HTN)
___Hyperthyroidism
___Hypothyroidism
___Heart Problems
___Infertility
___Kidney Disease
___Lung Disease
___Meniere's Disease
___Mental Illness
___Pulmonary Embolism
___Seizures/Epilepsy
___Stroke/TIA
___Tuberculosis
___Varicosities

HEALTH MAINTENANCE: Fill in all that apply

Date of last eye exam:
Date of last prostate exam:
Date of last PAP test:
Previous Mammogram:
Glasses/Contacts: Yes /No /Both

ALLERGIES:

Are you allergic to any medications: Yes / No
Please list:

____

____

____

____

Are you sexually Active: Yes / No

PAST SURGICAL HISTORY

Have you ever had surgery? Yes / No
(If yes, please list)

Type: ________________ **Year:** _______

Type: ________________ **Year:** _______

Type: ________________ **Year:** _______

Type: ________________ **Year:** _______

Type: ________________ **Year:** _______

MEDICATIONS

(List all medicines/supplements with dosages and frequency):

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ANYTHING ELSE YOU WILL WANT YOUR PROVIDER TO KNOW?