Free Clinic of Medina County

PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION SO WE MAY SERVE YOU BETTER

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP: _____

DOB: _____ AGE: _____ MALE / FEMALE Ethnicity: _____

SS #: _____

HOME PHONE #: _____ WORK #: _____

CELL PHONE #: _____

MARITAL STATUS: M S D W

How did you hear about us? □ Friend/Family □ Internet: _____

□ Physician: _____ □ Other: _____

EMERGENCY CONTACT

NAME: _____ PHONE #: _____

RELATIONSHIP: _____

PLEASE LIST EVERYONE LIVING IN YOUR HOUSEHOLD

LAST NAME	FIRST NAME	DOB	RELATIONSHIP

TOTAL HOUSEHOLD INCOME _____

(YEARLY, HOURLY, OR MONTHLY. MONTHLY INCOME PREFERABLE)

NUMBER OF MEMBERS IN HOUSEHOLD: _____

HOUSING STATUS: OWN RENT FAMILY/FRIENDS OTHER: _____

PLEASE CIRCLE THE HIGHEST LEVEL OF EDUCATION COMPLETED:

JUNIOR HIGH SCHOOL OR LOWER	HIGH SCHOOL	COLLEGE	GRADUATE
8-12 YEARS	12-14 YEARS	14-16 YEARS	> 16 YEARS

EMPLOYMENT STATUS (circle one):

CONTRACT FULL TIME PART TIME SELF TEMPORARY STUDENT UNEMPLOYED

EMPLOYMENT:

NAME: _____

ADDRESS: _____

YOU MUST PROVIDE US WITH FINANCIAL DOCUMENTATION AT THE TIME OF YOUR FIRST VISIT

I UNDERSTAND THAT THE ABOVE INFORMATION IS ACCURATE AND CAN BE VERIFIED.

_____ _____

Patient Name (Print) Date

_____

Patient Signature