# Page Free Clinic Patient Eligibility Form

(Revised 12/2019)

**NAME:** _____
Last First M.I.

**ADDRESS:** _____

**CITY:** _____ **STATE:** _____ **ZIP:** _____

**PHONE (H):** _____ **CALL/MESSAGE?** ☐ YES ☐ NO

**MOBILE PHONE:** _____ **TEXT?** ☐ YES ☐ NO

**EMAIL:** _____

**PREFERRED CONTACT:** ☐ HOME PHONE ☐ MOBILE PHONE ☐ EMAIL

**EMERG. CONTACT:** _____ **PHONE:** _____

**DATE OF BIRTH (mo/day/year):**

**SOCIAL SECURITY #:**

**SEX:** ☐ FEMALE ☐ MALE

**ETHNICITY:** ☐ HISPANIC ☐ NON-HISPANIC

**LANGUAGE:** ☐ ENGLISH ☐ SPANISH ☐ OTHER: _____

**Are you employed?** ☐ **YES** ☐ **NO**

**If YES, Where?** _____

☐ Full-time ☐ Part-time ☐ Seasonal

**Self-Employed?** ☐ **YES** ☐ **NO**

**Unemployed?** ☐ **YES** ☐ **NO**

**If YES, Why?**

☐ Disabled ☐ Retired ☐ Homemaker
☐ Due to health ☐ Unable to find work

**Race:**
- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Other: _____

**Marital Status:**
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Widowed
- ☐ Cohabitate

**Medical Insurance Status:**
- ☐ APPLIED for Medicaid
- ☐ Medicaid
- ☐ VA Benefits
- ☐ Medicare
- ☐ Private Insurance
- ☐ NONE

**If Homeless,**
- ☐ Shelter
- ☐ Street
- ☐ Live w/ others

**Active Workman's Compensation?**

☐ YES ☐ NO

**Drug Allergies:** ☐ YES ☐ NO

**If YES, List:**

**If you receive Social Security Benefits:**

☐ SSI ☐ RETIREMENT ☐ DISABILITY

**IMPORTANT: Proof of household income may be requested more than once per year.**

**Do you receive SNAP (food stamp) benefits?** ☐ YES ☐ NO If yes, how much? $_____

**# of People in the Household:** _____

| Name of Household Member | Age | Relationship to Patient | Income Source (Job, SS, etc.) | Gross Monthly Amount |
|---|---|---|---|---|
| **Patient:** | | SELF | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | **Total:** | $ |

**PATIENT AGREEMENT/DISCLOSURE:** I attest that this information is true and accurate. I understand that in order to be a patient at the Page Free Clinic I must comply with all requirements. I understand that if I knowingly withhold information or provide false information, it may be grounds for permanent dismissal and I will be responsible for any bills incurred. I give the Page Free Clinic staff permission to discuss and verify any and all information. I further give Page Free Clinic permission to share this information with Page Free Clinic if I am referred there for services.

I do not have prescription drug coverage. I agree to allow the Page Free Clinic to complete any patient assistance enrollment process on my behalf, which may include disclosure of personal and medical information. I also authorize the Page Free Clinic to share medical and financial information with any and all pharmaceutical providers and RxPartnership for eligibility and audit purposes. I will immediately notify the Free Medical Clinic of any changes to my income, household size, or insurance status.

**Signature:** _____

**Date:** _____

**For Staff Use ONLY:**

| | Date | Initials |
|---|---|---|
| Application : | | |
| Consent Form: | | |
| Photo ID | | |
| Social Security Card: | | |
| IRS Form: | | |
| POI: | | |
| LOS: | | |

**Eligible for:**
- ☐ All Services
- ☐ No PAP
- ☐ Dental Only

Expires: _____

Issued by: _____

Date: _____

☐ **NOT ELIGIBLE:** _____

**Patient ID:**

Name of Family Dr. or Clinic:_____ Date last seen by Dr.:_____

Date of last physical:_____ Currently being treated elsewhere? Y or N

Type of medical problems currently being treated: _____

Medication allergies: _____Yes _____No List: _____

Other allergies:_____

**Medications**: List all currently being taken or discontinued in the last 30 days. Include birth control pills and over the counter medications also.

| Name of medication | Dosage | How often taken | Doctor who Prescribed | How Long Taken? | Prescription or Over the counter? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**No Medications Taken:_____**

**MEDICAL HISTORY**: PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

| | | | |
|---|---|---|---|
| ___AIDS | ___Bronchitis | ___Nerve problems | ___Abnormal bleeding |
| ___HIV+ | ___Fainting | ___Heart problems | ___Gallbladder disease |
| ___Cancer | ___Cataracts | ___Liver disease | ___Headaches |
| ___Stroke | ___Jaundice | ___Depression | ___Kidney stones/disease |
| ___Asthma | ___Diabetes | ___Seizures/Epilepsy | ___Alcohol/Drug Abuse |
| ___Anemia | ___Hepatitis | ___Lupus | ___Psychiatric Problems |
| ___Ulcers | ___Pneumonia | ___Severe Arthritis | ___Gonorrhea/Syphilis |
| ___Genital Herpes | ___Colitis | ___Bloody Stools | ___Thyroid/Goiter |
| ___Rheumatic Fever | ___Glaucoma | ___Heart Attack | ___Urine Infections |
| ___Hemorrhoids | ___Emphysema | ___Tuberculosis | ___Nervous Problems |
| ___Smoking | ___Birth defect | ___Smoking | ___High Blood Pressure |
| ___Blood disease | ___Heart Murmur | ___Night sweats | ___Low Blood Pressure |
| ___Birth defect | ___Recent weight loss | | |

Smoker ___No ____Yes How many packs per day? _____ for how many years?_____

Past surgeries/injuries/hospitalizations and dates:_____