Time received: _____

Patient Demographics

Last name: _____ First name:_____Gender: ☐Male ☐Female

Date of Birth: _____ Street Address: _____ City: _____ Zip:_____

County of Residence: _____ Home Phone: _____ Mobile Phone: _____

Can we text you? ☐Yes ☐ No Do you give consent for automated appointment reminder calls? ☐ Yes ☐No

Email: _____ Preferred Language: ☐English ☐Spanish ☐Other:_____

Have you visited a hospital in the last 6 weeks? ☐Yes, visited an ER ☐Yes, admitted to a hospital ☐No ☐Decline to answer

If Grace Clinic wasn't open today, where would you go for medical care? ☐Don't know ☐Hospital ☐Urgent Care

☐Doctor's Office ☐Wouldn't get care ☐Decline to answer

Based on your family size, is your income LESS THAN the amount listed below? ☐Yes ☐No Initial: _____

2018 Federal Poverty Guidelines (200%) For the 48 contiguous states and the District of Columbia			
Family Size	**Yearly Income (before tax)**	**Monthly Income (before tax)**	**Weekly Income (before tax)**
1	$24,280	$2,023	$467
2	$32,920	$2,743	$633
3	$41,560	$3,463	$799
4	$50,200	$4,183	$965
5	$58,840	$4,903	$1,132
6	$67,480	$5,623	$1,298
7	$76,120	$6,343	$1,464
8	$84,760	$7,063	$1,630
Each Additional	$8,640	$720	$166

Do you have medicaid or other insurance? ☐Medicaid ☐Other Insurance ☐No Insurance

Would you like to pray with our prayer team after your medical visit? ☐Yes ☐No

How did you hear about us? ☐ Advertising ☐ Word of mouth ☐Primary Care Physician ☐Hospital ☐Other : _____

If you are registering a patient under the age of 18, please complete the information below:

Parent/Guardian's Last Name: _____ Parent/Guardian's First Name: _____

Parent/Guardian's Phone: _____ Parent/Guardian's Email: _____

Your relationship to patient: ☐Mother/Father ☐Guardian ☐Other: _____

Consent for Treatment

I hereby consent to the provision of care, diagnosis and/or treatment by the Grace Clinics of Ohio, Inc. and I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing.

I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the care, diagnosis and/or treatment and am not subject to duress or under undue influence.

_____ _____

Signature of Patient or Person Authorized to Consent* **Date**

_____

Relationship to Patient

*If this consent is signed by someone other than the patient, it must be signed in the patient's presence.

Please review the following statements and initial on the line provided.

Review of Patient Rights & Responsibilities

_____ I have read and I understand the Patient Rights & Responsibilities as posted in Grace Clinic Delaware. I have had the opportunity to ask questions or request explanation from a Grace Clinic Delaware volunteer and/or staff member.

Review of Limited Liability

_____ I have read and I understand the notice of Limited Liability for Free Clinic Volunteer Health Care Professionals, Board Members, Officers, Employees, and Independent Contractors as posted in Grace Clinic Delaware. Being mentally competent and under no duress or undue influence, I am giving informed consent to the qualified immunity that extends to health care providers of Grace Clinics of Ohio, Inc. who provide diagnosis, care, or treatment as long as no compensation is received or expected and is provided in a free clinic.

graceclinic
OF DELAWARE
A FREE MEDICAL MINISTRY
LOVE GOD...LOVE PEOPLE

Patient Name: _____

Health History

Do you have a primary care physician? ☐No ☐Yes- If yes, please add your PCP's information below:

PCP Name: _____ PCP Phone:_____

PCP Address: _____

Reason for your visit today: _____

Drug Allergies: _____

Other Allergies: _____

Please check if you have or have had any of the following:

__ADD/ADHD
__ AIDS/HIV
__ Acid Reflux
__ Acne
__ Anemia
__ Anxiety Disorder
__ Arthritis
__ Artificial Joints
__ Asthma
__ Autism Spectrum Disorder
__ Autoimmune Disease
__ Bladder or Kidney Problems
__ Blood Clots
__ Blood Disorder
__ Breast Problem
__ COPD
__ Cancer
__ Congestive Heart Failure
__ Constipation
__ Coronary Artery Disease
__ Depression
__ Diabetes
__ Diabetic Eye Disease
__ Dialysis
__ Diverticulosis
__ Double Vision
__ Ear or Hearing Problems
__ Eczema
__ Edema
__ Emphysema
__ Endometriosis
__ Fibromyalgia
__ Flomax Use
__ GI Problems
__ Gastrointestinal Disease
__ Gout
__ Head Injury/Concussion
__ Headaches
__ Heart Attack
__ Heart Problems
__ Hepatitis
__ Hernia
__ High Cholesterol
__ History of STI
__ History of Abnormal PAP
__ Hypertension
__ Hyperthyroidism
__ Hypothyroidism
__ Kidney Disease
__ Kidney Stones
__ Leg or Foot Ulcers
__ Liver Disease
__ Lung Disease
__ MRSA Exposure
__ Meningitis
__ Mental Illness
__ Multiple Sclerosis
__ Muscle, Joint, or Bone Problems
__ Neck Injury
__ Neurologic Disorder
__ Neuropathy
__ Organ Transplant
__ Osteoporosis
__ Other
__ Pacemaker
__ Peripheral Vascular Disease
__ Seizures/Epilepsy
__ Skin Problems
__ Sleep Apnea
__ Stroke
__ Tuberculosis
__ Ulcers

Please list any other medical conditions not already listed that you have or have had in the past: _____

_____

_____

Patient Name: _____

graceclinic OF DELAWARE
A FREE MEDICAL MINISTRY
LOVE GOD...LOVE PEOPLE

Social History

Please answer the following questions to the best of your ability. Your answers are confidential and will only be shared with your medical team.

What is your alcohol intake? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy Years of alcohol use: _____

Chewing tobacco use: ☐ None ☐ 1x/day ☐ 2-4x/day ☐ 5+/day

Concerns about meeting basic needs such as housing, heat, etc. ☐ Yes ☐ No

Currently pregnant? ☐ Yes ☐ No ☐ N/A

Do you feel like harming yourself? ☐ Yes ☐ No

Do you feel threatened in a relationship? ☐ Yes ☐ No

Do you feel threatened in your home environment? ☐ Yes ☐ No

Do you have a history of substance abuse treatment? ☐ Yes ☐ No

Have you ever purposely harmed yourself? ☐ Yes ☐ No

Do you use illicit drugs? ☐ Yes ☐ No Years of drug use: _____

In the last 12 months has the food you bought not lasted and you did not have enough money to buy more?

☐ Very True ☐ Somewhat True ☐ Never True ☐ Unsure or Decline to answer

In the last 12 months have you worried that your food would run out before you got money to buy more?

☐ Very True ☐ Somewhat True ☐ Never True ☐ Unsure or Decline to answer

Is there a history of emotional abuse? ☐ Yes ☐ No

Is there a history of physical abuse? ☐ Yes ☐ No

How many children live in your household? _____

Are you a smoker? ☐ Yes ☐ No ☐ Previous smoker _____ Current packs per day? _____ Years of use

Exercise level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Are you currently employed: ☐ Yes ☐ No

Live alone or with others: ☐ Alone ☐ Others

General stress level: ☐ Low ☐ Medium ☐ High

graceclinic
OF DELAWARE
A FREE MEDICAL MINISTRY
LOVE GOD...LOVE PEOPLE

Patient Name: _____

Release of Information

I, _____ hereby give Grace Clinic permission to release health records and/or give verbal information about my health to any and all healthcare providers from whom I may seek additional care or treatment arising from and reasonably related to the services provided by Grace Clinic. I also give any and all healthcare providers from whom I may seek additional care or treatment from and reasonably related to the services provided by Grace Clinic, permission to obtain copies of health records and/or to receive verbal information about my health. I understand that the information released and/or obtained will be used only for the purposes of providing care at Grace Clinic or for other reasons only after a release has been signed for that particular purpose. If the patient is a minor, (under 18 years of age), the parent or guardian is responsible for signing the release.

I give Grace Clinic Delaware permission to share my health information with the following individuals:

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

_____ _____

Signature of Patient or Person Authorized to Consent* **Date**

_____

Relationship to Patient

*If this consent is signed by someone other than the patient, it must be signed in the patient's presence.

Patient Name: _____

graceclinic OF DELAWARE
A FREE MEDICAL MINISTRY
LOVE GOD...LOVE PEOPLE