Grace Clinics of Ohio

Patient Demographics **Today's Date** _____

Last name: _____ **First name:** _____ **Sex:** ☐ Male ☐ Female

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

Zip: _____ **County:** _____ **Home Phone:** _____ **Mobile Phone:** _____

Do you give consent for appointment reminder: Texts? ☐ Yes ☐ No Calls? ☐ Yes ☐ No

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

Race: _____ **Ethnicity:** _____ **Marital Status:** _____

Reason for today's visit _____

Do you meet the Grace Clinic income guidelines listed below? ☐ Yes ☐ No Initial: _____

2023 Federal Poverty Guidelines (200%) For the 48 Contiguous States and the District of Columbia			
Persons in Family/Household	Yearly Income (Before tax)	Monthly Income (Before tax)	Weekly Income (Before tax)
1	$29,160	$2,430	$561
2	$39,440	$3,287	$758
3	$49,720	$4,143	$956
4	$60,000	$5,000	$1,154
5	$70,280	$5,857	$1,352
6	$80,560	$6,713	$1,549
7	$90,840	$7,570	$1,747
8	$101,120	$8,427	$1,945
Each additional person adds	$10,280	$857	$198

Do you have insurance? ☐None ☐Medicaid ☐Other Insurance

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

How did you hear about us? ☐**Internet** ☐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 Name: _____ Date of Birth: _____

Parent/Guardian's Address (if different from patient): _____

Parent/Guardian's Phone (if different from patient): _____

Relationship to Patient: ☐Mother/Father ☐Guardian ☐Other: _____

Release of Billing 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 Clinics of Ohio permission to share my health information with the following individual:

Name: _____ Relationship: _____ Phone Number: _____

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: _____ Date: _____

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.

Telemedicine Consent Form

_____ I have read and I understand the Telemedicine Consent Form, and authorize Grace Clinic to allow me/the patient to participate in a telemedicine (video confrencing service)

Social History

Home and Environment - Are there any smokers in your house? ☐Yes ☐No

Substance Use

Do you or have you ever smoked tobacco? ☐Never ☐Former ☐Current everyday ☐Current some days

How much tobacco do you smoke? ☐1 pack/week ☐2 packs/week ☐1/4 pack/day ☐1/2 pack/day ☐1 pack/day ☐2 packs/day

How many years have you smoked tobacco? _____

At what age did you start smoking tobacco? _____

Do you or have you ever used any other forms of tobacco or nicotine? ☐Yes ☐No

Do you or have you ever used e-cigarettes or vape? ☐Never ☐Former ☐Current

Do you or have you ever used smokeless tobacco? ☐Never ☐Former ☐Current - Snuff ☐Current - Chew ☐Current - Powder

What is your alcohol intake? ☐ None ☐Occasional ☐Moderate ☐Heavy

Do you use illicit drugs? ☐Yes ☐No

Activities of Daily Living

Are you able to care for yourself? ☐Yes ☐No

Are you blind or do you have difficulty seeing? ☐Yes ☐No

Are you deaf or do you have difficulty hearing? ☐Yes ☐No

Do you have difficulty walking or climbing stairs? ☐Yes ☐No

Do you have transportation difficulties? ☐Yes ☐No

Education and Occupation - Are you currently employed? ☐Yes ☐No

Advance Directive

Do you have an advanced directive? ☐Yes ☐No

What is your code status? ☐Full Code ☐DNR ☐DNI ☐ DNR/DNI ☐CMO

Diet and Exercise - What is your exercise level? ☐None ☐Occasional ☐Moderate ☐Heavy

Marriage and Relationship

What is your relationship status? ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Domestic Partner

How many children do you have? _____

Lifestyle

Do you feel stressed? (tense, nervous, anxious, or unable to sleep at night?) ☐Not at all ☐A little ☐To some extent ☐Very much

Grace Clinic Screening

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

Have you ever purposely harmed yourself? ☐Yes ☐No

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

☐Often true ☐Sometimes 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?

☐Often true ☐Sometimes true ☐Never true ☐Unsure or Decline to answer

Do you have a history of being emotionally abused? ☐Yes ☐No

Do you have a history of being physically abused? ☐Yes ☐No

Do you have concerns about meeting basic needs such as housing, heat, etc.? ☐Yes ☐No

Past Medical History

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

__ ADDP/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