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:** _____ **# of children?** _____

Do you meet the Grace Clinic income guidelines? ☐ Yes ☐ No **Do you have insurance?** ☐No ☐Medicaid ☐Other

Would you like to pray with our prayer team during your visit? ☐Yes ☐No **Religious Preference?** _____

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

Parent/Guardian's Name: _____ Relationship to Pt: ☐Mother/Father ☐Guardian ☐Other:

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

Reason for today's visit _____

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.

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 / Guardian: _____ 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 Clinics of Ohio. I have had the opportunity to ask questions or request explanation from a 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 of Ohio. 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

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

Photo Release Consent

_____ I authorize Grace Clinics of Ohio to use my photos/videos for promotional materials, advertisements, social media, and other communications, without payment. This permission applies to all formats and markets, now and in the future, and continues indefinitely unless I revoke it in writing. I understand these materials will become the property of Grace Clinics of Ohio and will not be returned.
I release Grace Clinics of Ohio from all liability related to the use of these materials

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? _____

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

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

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

Do you have an Advance Directive? ☐Yes ☐No **What is your code status?** ☐Full Code ☐DNR ☐DNI ☐ DNR/DNI ☐CMO

Lifestyle - Do you feel stressed? ☐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/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

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

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

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