LEBANON FREE CLINIC

Enrollment application form

Name:	Date of birth:	SS#:
Address:	City:	Zip code:
Cell phone:	Home phone:	Other:

Can we leave a message on your voice mail? Yes ☐ No ☐

Emergency contact:	Phone number:
Relationship:	

Gender: Female☐ Male☐ Other☐ _____

Marital status: Single☐ Married☐ Widowed☐ Divorced☐

Race/ethnicity (optional): Caucasian☐ African American☐ Hispanic☐ Asian☐ Middle Eastern☐ Other _____

What language do you prefer? English☐ Spanish☐ Other _____

Do you have health insurance? Yes☐ No☐ If yes, name insurance company _____

Do you receive? SSI☐ SSD☐ Medical assistance☐ Medicare☐ WIC☐ None☐

Have you applied to Medical Assistance in the past year? Yes☐ No☐

If yes: Pending☐ Denied☐

Are you employed? No☐ Full-time☐ Part-time☐ Self-employed☐

If yes name of employer _____

Housing: Rent☐ Own☐ Live with family☐ Live with friends☐ Shelter☐ Other:_____

Total household members:	
# of people 1yr to 18 yrs old:	# of people 19 yrs and older:

House Monthly income	**YES**	**House Monthly income**	**YES**
Less than $2,613		Between $3,534-$4,454	
Between $2,614- $3,533		Between $4,455 - $5,374	
Between $3,534-$4,454		Above $5,375	

I _____ (print name) certify that the foregoing information is true.

_____ _____

Date Signature

Lebanon Free Clinic

Medical History

Name/Nombre _____DOB/Fecha nacimiento: _____

Allergies/Alergias: _____

Anemia	☐Yes/Si ☐No	GERD/ Reflujo	☐Yes/Si ☐No	Hepatitis B or C	☐Yes/Si ☐No
Blood clots Coágulos de sangre	☐Yes/Si ☐No	High blood pressure Presión alta	☐Yes/Si ☐No	Venereal disease Enfermedad venerea	☐Yes/Si ☐No
Anxiety/depression Ansiedad/depresión	☐Yes/Si ☐No	Faint or Dizzy Desmayo o mareo	☐Yes/Si ☐No	Sleep apnea Apnea del sueño	☐Yes/Si ☐No
Arthritis/Artritis	☐Yes/Si ☐No	Infectious disease Enfermedad infectosa	☐Yes/Si ☐No	Thyroid problems Problema tiroides	☐Yes/Si ☐No
Asthma/COPD Asma/COPD	☐Yes/Si ☐No	High cholesterol Colesterol alto	☐Yes/Si ☐No	Osteoporosis	☐Yes/Si ☐No
Blood disease Problemas de sangre	☐Yes/Si ☐No	Migraines Migrañas	☐Yes/Si ☐No	Liver problems Enfermedad hepática	☐Yes/Si ☐No
Intestinal problems Problemas intestinales	☐Yes/Si ☐No	Sinus problems Sinusitis	☐Yes/Si ☐No	Sclerosis	☐Yes/Si ☐No
Persistent cough Tos persistente	☐Yes/Si ☐No	Mental illness Enfermedad mental	☐Yes/Si ☐No	Back problems Problemas de espalda	☐Yes/Si ☐No
Diabetes Type I or II	☐Yes/Si ☐No	Heart attack Ataque al corazon	☐Yes/Si ☐No	Obesity Obesidad	☐Yes/Si ☐No
Diarrhea/ Diarrea	☐Yes/Si ☐No	Heart Murmur pacemaker Soplo o marcapaso	☐Yes/Si ☐No	Stroke Derrame cerebral	☐Yes/Si ☐No
Eye disease Enfermedad de ojos	☐Yes/Si ☐No	Cancer	☐Yes/Si ☐No	Tuberculosis	☐Yes/Si ☐No
Edema	☐Yes/Si ☐No	Circulation problems Problemas de circulación	☐Yes/Si ☐No	Prostate problems Problemas de prostata	☐Yes/Si ☐No
Epilepsy/ epilepsia	☐Yes/Si ☐No	Ulcers Uceras	☐Yes/Si ☐No	AIDS/HIV	☐Yes/Si ☐No

Surgeries/ Cirugias:

☐ Gallbladder / Vesícula biliar ☐ Appendectomy/Apendicectomia ☐Tubal ligation/ ligadura de trompas

☐ Hysterectomy/ Histerectomía ☐ Masectomy/ Masectomia ☐Heart Surgery/Cirugia cardíaca

☐C-section / cesarea ☐Other/otra: _____

Medicines and dose/ Medicinas y dósis: _____ _____

_____ _____ _____

_____ _____ _____

In the past year, have you been in the ER/ En el último año ha estado en la sala de emergencias? ☐Yes ☐No

Reason/Razón_____

_____

Lebanon Free Clinic

Medical History

Name/Nombre: _____DOB/Fecha de Nacimeinto:_____

Social

Have you ever used tobacco? Yes☐ No☐ If yes, type: _____ Daily quantity?_____ Quit? Yes ☐ No☐

Ha usado tabaco? Si☐ No☐ Si, tipo: _____ Cantidad diaria?_____ Dejo de usar? Yes ☐ No☐

Have you ever drank alcohol? Yes☐ No☐ If yes, type: _____ Daily quantity?_____ Quit? Yes ☐ No☐

Ha tomado alcohol? Si☐ No☐ Si, tipo: _____ Cantidad diaria?_____ Dejo de usar? Yes ☐ No☐

Have you ever used drugs? Yes☐ No☐ If yes, type: _____ Daily quantity?_____ Quit? Yes ☐ No☐

Ha usado drogas? Si☐ No☐ Si, tipo: _____ Cantidad diaria?_____ Dejo de usar? Yes ☐ No☐

Do you drink coffee? Yes☐ No☐ Yes, how many cups a day? _____

Toma café? Si☐ No☐ Si, cuantas tazas al dia? _____

Are you under a lot of pressure at work☐ or home☐? Yes☐ No☐

Se siente con bastante stress en su trabajo☐ o casa☐? Si☐ No☐

Do you feel safe in your current living environment? Yes☐ No☐

Se siente seguro en su ambiente de vida? Yes☐ No☐

Do you have any needs (food, clothing, counselling)? Yes☐ No☐

Tiene alguna necesidad (comida, ropa, consejería)? Yes☐ No☐

Religious preference? _____ Would you like information on local house of worship? Yes☐ No☐

Preferencia religiosa _____? Le gustaría recibir información sobre Iglesias, templo etc? Yes☐No☐

Prior to The Lebanon Free Clinic, did you have a Primary Care Physician? Yes ☐ No☐

If yes Name of Practice _____ Address _____

Antes de la Clínica Gratis de Lebanon, tenia ún Médico Primario? Si No

Si, Nombre de la Práctica _____ Dirección _____

Lebanon Free Clinic

Free Clinical Federal Tort Claims Act (FTCA) Program

Notice if Limited Liability of FTCA Deemed Volunteer Free Clinic Health Care Professional

This is to notify you that under Federal Law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (see 28 U.S.C. 1346(b), 2671-80) provides the exclusive remedy from damage from personal injury, including death, resulting from the performance of medical, surgical, dental or related functions by any free clinic volunteer health care practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Services. This FTCA medical malpractice coverage applies to the deemed free clinic volunteer health care practitioners who have provided a required or authorized service under the Title XIX of Social Security Act (i.e. Medicaid Program) at the free clinic site or through offsite programs or event carried out by the free clinic (see 42 U.S.C & 233(A), (o).

Certain free clinic health care professionals providing health care services to patients at this free clinic may be covered by the above Federal Law.

Date: _____

Acknowledged:

_____ Patient's signature

_____ Patient's name

LEBANON FREE CLINIC " NO SHOW" POLICY

Lebanon Free Clinic implemented a "No Show" policy as of October 1, 2010.

Please be advised that you must notify the Clinic of the need to cancel by 8am the day before your appointment or it will be counted as a "No Show". You can leave a message 24 hours a day, 7 days a week on the clinic phones.

After a third (3rd) "No Show" appointment in 6 months you will be denied service. It is your responsibility to seek medical service elsewhere.

I _____ (print name) have read the "No Show" policy terms and understand the consequences of failing three (3) appointments in six (months).

_____ _____

Date Signature