

**Free Clinic of Meridian  
Patient Registration**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Any other phone number \_\_\_\_\_ May we leave a message? yes no

Email Address: \_\_\_\_\_ U.S. Citizen: yes no

How many people live in your household? \_\_\_\_\_ What are their ages? \_\_\_\_\_

Current income for the entire household: \_\_\_\_\_ per: week month year

Your Employer: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_

Spouse Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Employer's Phone: \_\_\_\_\_

Are you  Disabled  Unemployed Have you applied for Disability?  Yes  No  
Have you applied for Unemployment?  Yes  No

Disability Income \_\_\_\_\_ per  month  year Unemployment Income \_\_\_\_\_ per  month  year

Do you have any type of insurance?  Work  Medicare  Medicaid  Other

Have you applied for Medicaid or Medicare?  Yes  No If yes, were you turned down?  yes  no

If yes, why were you turned down? \_\_\_\_\_

Marital Status:  Married  Single  Widowed  Divorced

Ethnicity:  African American  White  Hispanic  Asian  Other

Who referred you to our clinic? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Contact Phone # \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Eligible  Ineligible (Explain below) Name of reviewer \_\_\_\_\_ Date \_\_\_\_\_

If ineligible, why?  Insured  Medicaid  Medicare  Under 19

Above income requirements Other \_\_\_\_\_

**For Office Use Only**

## Free Clinic of Meridian Patient Health History

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Who is your primary doctor or health care provider? \_\_\_\_\_ Date last seen \_\_\_\_\_

Reason for seeking medical care \_\_\_\_\_

Check **YES** if you have had any of the following:

| Yes |                     | When Diagnosed | Yes |                          | When Diagnosed |
|-----|---------------------|----------------|-----|--------------------------|----------------|
|     | Asthma              |                |     | Congestive Heart Failure |                |
|     | Emphysema           |                |     | Heart Attack             |                |
|     | High Blood Pressure |                |     | High Cholesterol         |                |
|     | Diabetes            |                |     | Cancer                   |                |

List any other health problems: \_\_\_\_\_

List all surgeries and hospitalizations:

| Type of Surgery | Date | Reason for Hospitalization (other than listed surgeries) | Date |
|-----------------|------|--|------|
|                 |      |  |      |
|                 |      |  |      |
|                 |      |  |      |
|                 |      |  |      |
|                 |      |  |      |
|                 |      |  |      |
|                 |      |  |      |
|                 |      |  |      |

Are you allergic to anything? \_\_\_No \_\_\_Yes If yes, please list allergies \_\_\_\_\_

List all medications you have been prescribed (Prescription and over-the-counter)

Are you currently out of any medications? \_\_\_Yes \_\_\_No

Highest grade completed in school \_\_\_\_\_ Occupation \_\_\_\_\_

Patient Signature

Date

**Free Clinic of Meridian**

**Authorization to Verify Patient Information**

Name (Please Print) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

*I hereby authorize the Free Clinic of Meridian to verify my income and availability of insurance by contacting my employer, my spouse's employer, the Mississippi Office of Medicaid, and/or the Office of Medicare.*

*I understand that having a household income above 200% of the Federal Poverty level for a household of my size or having any type of insurance will disqualify me from receiving care at The Free Clinic of Meridian.*

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

## Free Clinic of Meridian

Name (Please Print) \_\_\_\_\_

Date of Birth \_\_\_\_\_

### Privacy Practices Acknowledgement:

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it. I acknowledge that I understand the notice that has been provided to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Waiver of Liability:

I understand that the Medical Providers in the Free Clinic of Meridian have agreed to provide necessary medical care to me without compensation due to my inability to pay. I desire to be provided these services and am willing to waive my right to take legal action against the Medical Providers at the Free Clinic of Meridian for negligence that is not of either a wilful or gross nature.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Consent to Treatment

I hereby request that a person authorized by the Free Clinic of Meridian provide appropriate evaluation, testing, and treatment (including a birth control drug or device if I request it). I also authorize the Free Clinic of Meridian to transfer my medical records at the request of other medical providers to ensure continuity of care when I have been elsewhere for medical services. I also understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## QUESTIONNAIRE FOR PATIENTS WITH NO INCOME

If you presently do not have any income coming into your household, please answer the following:

1. Has anyone in your HOUSEHOLD received income this month such as cash, checks, gifts? \_\_\_Yes \_\_\_No

If so, how much? \_\_\_\_\_

2. Have you received financial assistance through any of the following community agencies in the past three months?

- a. Multi-County      \_\_\_Yes; \_\_\_\_\_Amount      \_\_\_No  
b. Wesley House      \_\_\_Yes; \_\_\_\_\_Amount      \_\_\_No  
c. Salvation Army      \_\_\_Yes; \_\_\_\_\_Amount      \_\_\_No  
d. DHS/SSI      \_\_\_Yes; \_\_\_\_\_Amount      \_\_\_No

If yes, what type of assistance did you receive? \_\_\_\_\_

\_\_\_\_\_

3. Do you receive child support? \_\_\_Yes; \_\_\_\_\_Amount      \_\_\_No

4. How are you paying your monthly bills? This includes rent, light bill, phone, gas, food. \_\_\_\_\_

\_\_\_\_\_