

Physicians' Care Clinic

Patient Application Form

A Volunteer Effort of the Dekalb Medical Society

Section 1: Do you have insurance that covers your health condition? Yes _____ No _____

Please Print

If yes, Name of Insurance Plan: _____ Policy #: _____

Do you have an active GA Medicaid card? Yes _____ No _____ Date issued: _____

Patient's Name: _____
 Last name First name Middle Initial Male Female

Address: _____
 Street City/State Zip

Home Telephone or Contact number: _____ Cell Phone: _____ Work Phone: _____

Social Security Number: _____ Date of Birth: _____

Single _____ Married _____ Divorced _____ Widowed _____

Nationality: _____ Race _____ Primary Language _____

Section 2:

Family Size: Adults _____ Under 18 _____ 18-21 Student _____ Unborn _____ Family Size Total _____

Family Member Name	Date of Birth	Employer	Net Earned Income Last 4 wks	Net Unearned Income Last 4 wks (do not include SSI)
Self:			\$	\$
Spouse:			\$	\$
Child:			\$	\$
Child:			\$	\$
Child:			\$	\$
Child:			\$	\$
Totals			\$	\$
				(add earned and unearned income to determine total)
				Total Income
				\$ _____

Section 3

- I understand that falsification of any information contained on this form will result in my inability to receive health care at the Physicians' Care Clinic.
- I acknowledge that failure to provide the Physicians' Care Clinic with an update on changes in my financial status may result in my inability to receive health care.
- I further acknowledge that I understand the Physicians' Care Clinic is staffed by volunteer physicians and staff. I accept treatment based on this knowledge.

Required Documents:

- Valid Picture ID attached to application (drivers' license, visa, passport, green card, state issued ID card)
- Proof of residency attached to application (rental lease, utility bill showing current address, notarized letter from landlord)
- Credit card statement(s) attached to application (if applicable)
- Proof of income attached to application (1 mo of check stubs; statement from employer on company letterhead; **wage inquiry statement from the Georgia Department of Labor, if unemployed**)
- Recent Bank Statement attached to application (if applicable)

Signature of Patient _____ Date _____

(Valid for one year) Expiration date: _____

Reason for first clinic visit: _____

How did you hear about the Physicians' Care Clinic? _____

MEDICAL HISTORY FORM

Print Name: _____ / _____ / _____
(Last) (First) (Middle) M or F Date of Birth

ALLERGIES	REACTION	ALLERGIES	REACTION

Have you had a cough for more than three weeks? **Yes** ___ **No** ___ If yes, have you been exposed to TB? **Yes** ___ **No** ___

Have you had a TB skin test? **Yes** ___ **No** ___ If yes, were the results **Positive** ___ **Negative** ___

If positive, have you been treated for TB? **Yes** ___ **No** ___

If yes, Describe: _____ Date: _____

Do you smoke? **Yes** ___ **No** ___ If yes, how many packs per day? _____ How many years have you smoked? _____

Do you drink alcohol? **Yes** ___ **No** ___ If yes, how much _____ How many years? _____

Do you have any history of drug or alcohol addiction? **Yes** ___ **No** ___ If yes, what type _____ Last treated _____

Current Medications	Dose	Current Medications	Dose	Current Medications	Dose

Do you communicate in English? **Yes** ___ **No** ___ If no, what language do you speak? _____

Please check yes or no if you have, or have had a history of any of the following:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Childhood Illnesses:			Infectious Disease:		
Measles	___	___	HIV/AIDS	___	___
Mumps	___	___	Syphilis	___	___
Rubella	___	___	Other STD	___	___
Rheumatic fever	___	___	Gastrointestinal Problems		
Eye Problems			Ulcers	___	___
Glaucoma	___	___	Liver disease	___	___
Cataracts	___	___	Hepatitis	___	___
Glasses/contacts	___	___	Pancreatitis	___	___
Ear/Hearing Problems			Gall Bladder	___	___
Impaired	___	___	Diverticulitis	___	___
Hearing Aid	___	___	Hemorrhoids	___	___
Sinus Problems			Bowel problem	___	___
Allergies	___	___	Kidney/Urinary Problems		
Hayfever	___	___	Bladder Infections	___	___
Infections	___	___	Kidney Stones	___	___
Lung Problems			Prostate	___	___
Oxygen dependent			Nervous System Disorders		
Asthma	___	___	Seizures/Epilepsy	___	___
Emphysema	___	___	Headaches	___	___
COPD	___	___	Migraines	___	___
Pneumonia	___	___	Endocrine Disorders		
Tuberculosis	___	___	Thyroid disease	___	___
Heart/Vascular Problems			Diabetes	___	___
Hypertension	___	___	Insulin	___	___
Heart Murmur	___	___	Pituitary disease	___	___
Heart Attack	___	___	Blood Disorders		
High Cholesterol	___	___	Anemia	___	___
Stroke	___	___	Leukemia	___	___
Blood Clots	___	___	Blood Transfusion	___	___
Muscle/Bone/Joint Problems			Skin Disorders		
Arthritis	___	___	Rash/Hives	___	___
Gout	___	___	Eczema	___	___
Breast Problems	___	___	Cancer/Tumors	___	___
Female Problems	___	___	Emotional Problems	___	___

List any **major surgeries** with dates: _____

Please use the following space or the back of this page to explain further any of the "yes" answers to the questions above or to write any health problem not listed: _____

Signed: _____ **Date** _____

PHYSICIANS CARE CLINIC

Physicians' Care Clinic

A Volunteer Effort of the DeKalb Medical Society

Thank you for your interest in the Physicians' Care Clinic. To qualify for the clinic you must be an **uninsured DeKalb County resident** with limited income.

Our medical staff are all Volunteers working at their own practices during the day and at the clinic on Wednesday and Thursday evenings, from 6pm – 8pm, providing care for adults with **minor illnesses only**.

We do not provide emergency care, trauma injury care, dental care, STD or pregnancy testing or do "well-care" physicals.

Upon receipt of all the requested information, we will review your application for eligibility. If you are approved we will call to schedule an appointment with you.

Completed applications must be sent to the administrative office.

Mail to: Physicians' Care Clinic
 2675 N. Decatur Road, Ste. 610
 Decatur, GA 30033
Fax to: 404-501-7199

Each clinic visit is \$18.00