

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:						
Measles	___	___				
Mumps	___	___				
Rubella	___	___				
Rheumatic fever	___	___				
Eye Problems						
Glaucoma	___	___				
Cataracts	___	___				
Glasses/contacts	___	___				
Ear/Hearing Problems						
Impaired	___	___				
Hearing Aid	___	___				
Sinus Problems						
Allergies	___	___				
Hayfever	___	___				
Infections	___	___				
Lung Problems						
Oxygen dependent	___	___				
Asthma	___	___				
Emphysema	___	___				
COPD	___	___				
Pneumonia	___	___				
Tuberculosis	___	___				
Heart/Vascular Problems						
Hypertension	___	___				
Heart Murmur	___	___				
Heart Attack	___	___				
High Cholesterol	___	___				
Stroke	___	___				
Blood Clots	___	___				
Muscle/Bone/Joint Problems						
Arthritis	___	___				
Gout	___	___				
Breast Problems	___	___				
Female Problems	___	___				
Infectious Disease:						
HIV/AIDS	___	___				
Syphilis	___	___				
Other STD	___	___				
Gastrointestinal Problems						
Ulcers	___	___				
Liver disease	___	___				
Hepatitis	___	___				
Pancreatitis	___	___				
Gall Bladder	___	___				
Diverticulitis	___	___				
Hemorrhoids	___	___				
Bowel problem	___	___				
Kidney/Urinary Problems						
Bladder Infections	___	___				
Kidney Stones	___	___				
Prostate	___	___				
Nervous System Disorders						
Seizures/Epilepsy	___	___				
Headaches	___	___				
Migraines	___	___				
Endocrine Disorders						
Thyroid disease	___	___				
Diabetes	___	___				
Insulin	___	___				
Pituitary disease	___	___				
Blood Disorders						
Anemia	___	___				
Leukemia	___	___				
Blood Transfusion	___	___				
Skin Disorders						
Rash/Hives	___	___				
Eczema	___	___				
Cancer/Tumors	___	___				
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 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.

All 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