Please Print
Please complete all questions.
This information is used to help us receive funding.

Community Health Free Clinic Intake Form

Clipboard # _____

Today's Date _____

Name: First _____ MI _____ Last _____

SSN _____ **Birth Date** (M) _____ (D) _____ (Y) _____

Race
- ☐ White
- ☐ Black or African American
- ☐ American Indian/Alaska Native
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Chinese
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Other Race: _____

Gender
- ☐ Female
- ☐ Male

Employment Status
- ☐ Full Time
- ☐ Part Time
- ☐ Retired
- ☐ Student
- ☐ Unemployed

Language
- ☐ English
- ☐ Spanish
- ☐ Other: _____

Ethnicity
- ☐ Mexican
- ☐ Mexican American
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other Hispanic/Latino
- ☐ Not Hispanic or Latino

Marital Status
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Widowed
- ☐ Separated

Insurance
- ☐ Medicaid
- ☐ Medicare
- ☐ Uninsured
- ☐ Employer Provided Coverage
- ☐ Marketplace/Private Coverage

# of People in Household _____

Annual Household Income _____

Head of Household ☐ **(Y) Yes** ☐ **(N) No**

Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Work** _____ **Cell** _____

Primary Contact ☐ **Cell** ☐ **Home** **Email** _____

Signature required by patient, parent, or guardian giving consent to be treated. This information will be kept confidential and is used only for those purposes required to provide the requested medical services.

Sign Here: _____ Relationship to patient:_____

Continue to Medical History & Medication Sheet

Community Health Free Clinic
Medical History & Medication Sheet

Name _____ **Birth Date** _____ **Male** ☐ **Female** ☐

Are you to take Premed before Dental Treatment? Yes ☐ **No** ☐

Do you have or have you ever had? :

Heart Problems		**Radiation Treatment**	☐	**Extended Headaches**	☐
Disease	☐	**Lung (Asthma, etc.)**	☐	**Tuberculosis**	☐
Pacemaker	☐	**Anemia**	☐	**Chemical Dependency**	☐
Murmur	☐	**Sexually Transmitted Disease**	☐	**Alcohol Dependency**	☐
Mitral Valve Prolapse	☐	**AIDS/HIV & Related Complex**	☐	**Arthritis/ Joint Replacement**	☐
Artificial Valves	☐	**Hepatitis/Jaundice**	☐	**Fainting**	☐
Stroke	☐	**Rheumatic Fever**	☐	**Convulsions/Epilepsy**	☐
High Blood Pressure	☐	**Thyroid**	☐	**Other:**	
Cancer/Leukemia	☐	**Depression**	☐		

Any Surgeries? (Include approximate date):

1. _____ 2. _____ 3. _____

ALLERGIES:

General (Hay Fever, Dust, etc.) ☐ Aspirin ☐ Barbiturates/Sedatives ☐ Codeine ☐

Novocain ☐ Penicillin ☐ Latex ☐ Other _____

What local pharmacy do you usually use? _____

Medication Review				
Medication	**Dosage**	**Frequency**	**Medication Condition Being Treated**	**Comments**

To the best of my knowledge, the above questions have been accurately answered. I understand that incorrect information could affect my treatment and my health. This information will be treated as confidential.

_____

Patient, Parent, or Guardian Signature