Welcome to the Community Clinic of Joplin, we are glad you have found us!

“Our mission is to improve the health of people in our community without access to medical and dental care.”

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY!

We only serve Missouri residents residing in one of the following counties: Barton, Barry, Dade, Jasper, Lawrence, McDonald, Newton, & Vernon.

WE DO NOT PROVIDE WOMEN’S OR MENTAL HEALTH SERVICES

Please bring the following documents with your completed application.

1. PHOTO ID

2. PROOF OF HOUSEHOLD INCOME (include all persons living in the home who have a source of income):
   **Documents to provide:** Previous year’s tax form or a current pay stub.
   * If you are homeless please provide a letter from the shelter.

3. PROOF OF RESIDENCY:
   **Documents to provide:** Utility stub or recent mail with your name and current address.

* If you are on medications, please bring the medication bottles with you to every visit or you will be rescheduled. *

The Community Clinic is able to provide services today because volunteers have given their time to make a difference in our community. We ask that you do your very best to keep all scheduled appointments so that the Clinic is able to serve as many people as possible. In the case you are unable to keep an appointment; we ask that you notify the Clinic within 24 hours of your scheduled appointment by calling (417) 624-5500 ext. 11.

Thank you for allowing us to serve you today!
**PATIENT INFORMATION**

Today's Date: _________  Patient’s Legal Name________________________

Date of Birth _______________  Social Security Number ___________________________

First                  Middle Initial       Last

Gender:  Male_____ Female_____

Physical Address

Mailing address (if you don’t receive mail at above location)

Street  (NO PO BOX)       Apt#       City       State       Zip       County

Home or Message PHONE (____)-_________________________  May we leave a message with family member or on a machine?________

Emergency Contact Information: (someone with different information than your own)

Name                                                                                          Address

Phone Number \                                                                                   Relationship to you

Ethnicity: Caucasian____  African American____  Hispanic___  Asian____  Native American____  Other ________ (please specify)

Marital Status:  Single (never married) ____  Married ____  Divorced ____  Widowed_____ (please mark one)

Level of education completed?  Secondary____  High school/ GED _____  Some College____  College Degree ___ ( please mark one)

Are you currently homeless?  Yes ____  No _____  Are you currently living in a shelter?  Yes_____  No_____

**EMPLOYMENT INFORMATION**

Employer________________________________________________________________________________________________

Address (street, city, zip)  Phone#

**INSURANCE INFORMATION**

Does your employer offer Health Insurance?  Yes_____  No _____  Do you participate in your employer insurance?  Yes_____  No_____

If you answer “ no”, explain why?________________________________________________________

Do you have:  Medicaid?  Yes ____  No _____  Medicare?  Yes____  No ____  Indian Benefits?  Yes ____  No_____

Do you receive VA Benefits?  Yes ____  No ____  Are you a veteran?  Yes ____  No_____

Do you have any other type of insurance?  Yes____  No ____  Are you receiving disability benefits?  Yes____  No_____

**INCOME**

Monthly (Gross) Total Household Income Level: (Please Circle One)


Source of Income?

How many adults are living in your home? ________  How many children (under the age of 18) are living in your home? ________

Do you have any other needs we can assist you with?

________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
Date: _______  Patient Name: ____________________________________  Date of Birth: ___________________

What medical problem do you need to be seen for? __________________________________________________________

How long have you been experiencing this problem? __________________________________________________________

Have you been seen by any other doctor regarding this medical problem?  □Yes  □No

If yes, where were you seen? ___________________________________  Physician’s name ______________________

When and Where was your last health/doctor visit?  Date:_________  Where/Who? ________________________________

Are you currently seeing any other health providers?  □Yes  □No  Who/Where? ________________________________

ALLERGIES:  Are you allergic to the following:  X-ray dye? □Yes  □No  Latex? □Yes  □No  Iodine? □Yes  □No

Are you allergic to any medications?  □Yes  □No  If yes, please list ________________________________

PAST MEDICAL HISTORY:  Have you ever or do you now have any of the following problems:

- □ Allergies
- □ Anemia
- □ Arthritis
- □ Asthma
- □ Behavior Problems
- □ Blood Disorder
- □ Breast Lump
- □ Bronchitis
- □ Cancer
- □ Diabetes
- □ Emphysema/COPD
- □ Fever
- □ Headaches
- □ Heart Disease
- □ High Blood Pressure
- □ High Cholesterol
- □ Kidney Disease
- □ Liver Disease/Hepatitis
- □ Migraines/Headaches
- □ Multiple Sclerosis
- □ Nausea
- □ Pain
- □ Pneumonia
- □ Pneumothorax
- □ Pruritus
- □ Rash
- □ Seizures/Epilepsy
- □ Sinusitis
- □ Stomach Ulcers
- □ Strep Throat
- □ Tuberculosis
- □ Urinary Problems
- □ Wound Infection

CURRENT MEDICATION:  (Medicines, Vitamins, Home Remedies, Over the counter)

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SOCIAL HISTORY:  Tobacco Use? □none □Current Use □Prior Use □ Year Started? ____________  Year Quit ____________

Cigarettes/pipes/cigars/dips per day ______  Years ______  Are you interested in quitting?  □Yes  □No

Alcohol Use □None □Beer/Wine/Spirits □Rarely/Occasional □weekly □Daily □ Drinks/Week ______

Is your alcohol use a concern for you or others?  □Yes  □No

Do you use street drugs?  □Yes  □No  If yes, please list: ________________________________

Are you sexually active?  □Yes  □No  Birth control method? ________________________________

Have you ever had any SEXUALLY TRANSMITTED DISEASES?  □Yes  □No

FAMILY HISTORY:  Has any BLOOD relative had any of the following:

- □ Alcoholism
- □ Arthritis
- □ Blood Disorder
- □ Cancer
- □ Diabetes
- □ Headaches
- □ Heart Disease
- □ Hepatitis/Liver Disease
- □ Kidney Disease
- □ Mental Illness
- □ Stroke/TIA
- □ Lymph Node
- □ Seizures/Epilepsy
- □ Thyroid Disorder
- □ Other

FOR WOMEN ONLY:  Do you perform self-breast exams?  □Yes  □No  If yes, how often?

How many pregnancies have you had? ______  deliveries? ______  miscarriages? ______  abortions? ______

Last menstrual period? ____________  female check-up ____________  mammogram ____________

Have you ever had an abnormal Pap Smear? □Yes  □No  If yes, when was it? ____________

FOR MEN ONLY:  Do you perform self-breast exams?  □Yes  □No  If yes, how often?

Do you perform self-testicular exams? □Yes  □No  If yes, how often?

Have you ever had an abnormal prostate exam? □Yes  □No  If yes, when was it? ____________
Request and Authorization for Medical Care

1) I _______________________________ request & give consent for care at the Community Clinic. Initials_____ 

2) I certify that I do not have any type of health insurance (including Medicaid, Medicare or Indian or V.A. Benefits) Initials ____

3) I understand that a donation is requested at the time of service. Initials____

4) I understand that I may be given prescriptions for medications that will need to be purchased at a local pharmacy. Initials____

5.) I understand that I may be referred for additional medical test/services and I may possibly have financial obligation to those outside providers. This Clinic will assist with financial assistance paperwork if needed. Initials ______

6) I understand that the Clinic staff will make my appointments when referred to medical services outside of the Clinic. I will be contacted by Clinic staff to notify me of my referral information and appointment time. If I do not have a phone number where I can be reached, it is my responsibility to contact the Clinic for referral information at 417-624-5500 ext. 11. Initials____

7) I understand that if I must cancel an appointment I should contact the Clinic within 24 hours before my scheduled appointment. Failure to do so could result in future denial of services. Initials____

8) I certify that all information in this application form is true and complete. Initials ______

9) I release the Community Clinic of Joplin from any/all liability in regards to the care I receive. Initials____

PRINT Patient’s Name if minor child or Your Name: _______________________________________________

Signature ___________________________________________________________ Date __________

FEDERAL PRIVACY ACT LAW
Acknowledgement of Receipt of Notice of Privacy Practice

I have received a copy of the Privacy Practices for the Joplin Community Clinic. (Any information we receive is for office use only)

Name of Patient (please print) ______________________________________________________________

Patient Signature __________________________________________________________ Date __________

Signature of Patient Representative (Required if the patient is a minor or an adult who is unable to sign this form: ____________________________ Date _________________

Relationship of Representative to Patient: __________________________________________________