701 S. Joplin Avenue Joplin, Missouri 64801 ● Phone 417-624-5500 ●Fax 417 624-8228● joplinclinic.org

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.

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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!

____Community Clinic____

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PATIENT INFORMATION

Today's Date: _________ **Patient's Legal Name**____
First **Middle Initial** **Last**

Date of Birth _______________ **Social Security Number** ___________________________ **Gender: Male**_____ **Female**_____

Physical Address ____
Street (NO PO BOX) **Apt#** **City** **State** **Zip** **County**

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

____

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)

□$0 -$500 □$500 – $1000 □ $1000 – $1500 □$1500 -$2000 □$2000 – $2500 □$2500 – above

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	□ Depression	□ Skin Problem ____________
□ Anemia	□ Goiter	□ Seizures/Epilepsy
□ Arthritis	□ Gout	□ Stroke/TIA
□ Asthma	□ Heart Disease	□ Thyroid Problems
□ Behavior Problems	□ High Blood Pressure	□ Tuberculosis
□ Blood Disorder _____________	□ High Cholesterol	□ Ulcers/Stomach Problems
□ Breast Lump	□ HIV Positive	□ Surgery ___________________
□ Bronchitis	□ Kidney Disease/Urinary Problems	□ Surgery ___________________
□ Cancer ____________________	□ Liver Disease/Hepatitis	□ Surgery____________________
□ Diabetes	□ Migraines/Headaches	□ Surgery____________________
□ Anorexia or Bulimia	□ Multiple Sclerosis	□ Surgery ____________________
□ Emphysema/COPD		

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

Name/Strength/How Often	Name/Strength/How Often	Name/Strength/How Often

SOCIAL HISTORY: Tobacco Use? □none □Current Use □Prior Use □ Year Started? _________ Year Quit ________
Cigarettes/pipes/cigars/dips per day ______ Years _______ Are you interesting 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**	□ **Heart Disease**	□ **Stroke/TIA**
□ **Arthritis**	□ **Hepatitis/Liver Disease**	□ **Lymph Node**
□ **Asthma/Allergies**	□ **High Blood Pressure**	□ **Seizures/Epilepsy**
□ **Blood Disorder** _________________	□ **High Cholesterol**	□ **Thyroid Disorder**
□ **Cancer** _________________	□ **Kidney Disease**	□ **Tuberculosis**
□ **Diabetes**	□ **Lung Disease**	□ **Other** ______________
□ **Headaches**	□ **Mental Illness**	□

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:

____