Hannibal Free Clinic

Quality Healthcare-Caring Volunteers

PATIENT APPLICATION

_____

Last Name First Name Middle Name Maiden Name

_____

Date of Birth Social Security# Other names may be used on records

_____

Street Address City State Zip

_____

Home Phone Cell Phone Contact Phone

_____

Notify in case of Emergency Relationship Emergency Phone

List household members

List all household members (Including Self)	Relationship	Monthly Income	Income Source	Disability Yes/No
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
Total in		Total Income		
Household =				

NOTE: Please check all sources of Income and Benefits for your HOUSEHOLD. Bring copy of recent payroll stub with year to date totals, last year's tax return, AND any award letters when you return application. We MUST have proof of income before we process your application. Also, we MUST have updated proof of income by April 15th of each year.

Marital Status: Single Married Divorced Widowed Separated
Male Female Race_____ Religion_____
Are you a veteran? ___Yes ___No Have you filed for disability? ___Yes ___No

_____

Employer City State Phone

What health problems do you need to have treated at the clinic?_____

_____

How did you hear about the HANNIBAL FREE CLINIC? _____

Please list where you have previously received care and contact information and approximate dates of service if available. This will allow us to obtain your old records prior to your appointment.

Physician/Clinic	City	State	Phone	Dates
Physician/Clinic	City	State	Phone	Dates
Hospital	City	State	Phone	Dates
Hospital	City	State	Phone	Dates
Other	City	State	Phone	Dates
Other	City	State	Phone	Dates

I, _____, hereby authorize the above named parties to release information to the HANNIBAL FREE CLINIC, 160 Progress Road, Hannibal, MO 63401.

I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Part 2, and the Health Insurance Portability & Accountability Act of 1996 (HIPPA) and cannot be disclosed without written consent unless otherwise provided for in the regulations. I understand the information released may include, but is not limited to: history, diagnosis and/or treatment of drug and alcohol abuse, mental illness, or communicable disease including human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). I authorize the release of these specific data. I also understand that I may revoke this consent at any time, except to the extent that disclosures have already been made in reliance on this or any other consent. Revocation may be accomplished per written request and may be for specific items or the entire release. I understand this authorization will expire one year from the date of my signature or on ___/___/____ (DD/MM/YYYY). I understand I may be charged for copies of my medical records. I have read the above information and authorize the above mentioned organizations to release the identified information to the HANNIBAL FREE CLINIC. I understand by signing this document, I release the healthcare facility from any liability for any release made as a result of the authorization. This release is for continuation of care.

Signature of patient or patient's representative	Today's Date	Date of Birth

Please return completed application to 160 Progress Rd, Hannibal, MO 63401

Or fax to 573-248-8350 Please call 573-248-8307 with questions.