Date / /

Identifying information – Exactly as it appears on ID

First Name ______________________ Last Name ______________________

Sex – Check One ☐ Male ☐ Female Date of birth ______________ SSN ______________

PREFERRED LANGUAGE ☐ English ☐ Spanish ☐ Both ☐ Other ______________

Contact

MOBILE PHONE ______________________ OR ☐ Patient doesn't have a mobile phone

EMAIL ______________________ OR ☐ Patient doesn't have an email address

Patient/guardian has approved the following: ☐ Send mobile text notifications ☐ Leave a message

HOME PHONE ______________ WORK PHONE ______________

PREFERRED METHOD OF COMMUNICATION – Select one: ☐ email ☐ mail ☐ home phone ☐ cell phone – call ☐ cell phone - text

ADDRESS ______________________ Apartment # ______________

Zip ________ City ______________ State ________ County ______________

Demographics

ETHNICITY – Select One: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race(s) Select One: ☐ American Indian ☐ Asian ☐ Black ☐ Other ______________

Next of kin

First Name ______________________ Last Name ______________________

RELATION TO PATIENT – Check One: ☐Spouse ☐Parent ☐Sibling ☐Child ☐Guardian ☐Partner ☐Caregiver ☐Friend ☐Relative

PHONE ______________________

ADDRESS ______________________ Apartment # ______________

City ______________ State ________ Zip ________ County ______________

Notes

CITIZEN – Check One: ☐Yes ☐No VETERAN – Check One: ☐Yes ☐No

WORK STATUS – Check One: ☐Unemployed ☐Disabled ☐Spouse Works ☐Part Time Job ☐Full Time Job

HOW MANY PEOPLE IN IMMEDIATE FAMILY ________ FAMILY ANNUAL INCOME ______________

MARITAL STATUS – Check One: ☐Single ☐Married ☐Divorced ☐Widowed ☐Common Law ☐Separated

EDUCATION – Check One: ☐Grade School ☐Some High School ☐GED ☐High School ☐Some College ☐College Degree ☐Masters +

TO WHOM CAN WE RELEASE YOUR MEDICAL INFORMATION

NAME ______________________ RELATIONSHIP to PATIENT ______________

EMERGENCY CONTACT

NAME ______________________ RELATIONSHIP to PATIENT ______________ PHONE ______________

HOW DID YOU GET TO THE CLINIC TODAY – Check One: ☐Own Car ☐Borrowed Car ☐Friend/Family ☐Walked ☐Biked ☐Other

If you didn't come to our clinic, where would you go? ______________________

WHERE DID YOU HEAR ABOUT THE CLINIC – ☐Friend ☐Flier ☐St. William Church ☐St. David's Hospital ☐School ☐Seton Hospital ☐Website ☐Wilco-Health Department ☐211 ☐Lone Star Circle of Care ☐SHCC Volunteer ☐RR Serving Center ☐A Local Church ☐St. Vincent De Paul

Sacred Heart Community Clinic
620 Round Rock West Drive
Round Rock, TX 78681

Notice to Patients

To be provided to the individual patient before health care services are provided, except in emergency cases when notice may be provided as soon after the emergency as is practicable or to a parent or legal guardian when the patient lacks legal responsibility for his/her care under State law.

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner, board member, officer, employee, or independent contractor who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners, board member, officer, employee, or independent contractor who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (o)).

The above Federal law and other State and Federal laws including the Federal Volunteer Protection Act of 1997 may cover certain free clinic health care professionals providing health care services to patients at this free clinic.

Acknowledged:

____
(Patient signature)

____
(Patient name, printed legibly)

____
Date

Acknowledgement of Review of Notice of Privacy Practices- HIPAA

I have reviewed this Clinic's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

______________________________ ______________________________

Signature of Patient, Parent, Guardian or Personal Representative **Date**

INCOME DECLARATION AND FRAUD STATEMENT

TODAY'S DATE/FECHA DE HOY: ____________

PATIENT NAME/NOMBRE DE PACIENTE	SOCIAL SECURITY/NUMERO DE SEGURO SOCIAL

INCOME SCREENING TOOL

FOR OFFICE USE ONLY

	AMOUNT	COMMENTS
TOTAL HOUSEHOLD INCOME		
NUMBER IN HH (Include dependents claimed on tax return)		
SCREENER'S INITIALS		

FRAUD STATEMENT

I, ________________, do hereby affirm that the income I have declared is correct and can be verified if necessary.

- If my income should change, due to loss of job, new employment or income received from any source, I agree to report the change to the clinic where I receive health care.
- I understand that failing to report employment or income from any source could result in civil or criminal penalties. I may also be held responsible for full payment for any medical services received at the clinic.
- I understand that if I am under the age of 19, I may declare myself a household of one person and claim my own income for Family Planning services.

Yo, ____________________, afirmo que el ingreso declarado es el correcto Y puede ser verificado si es necesario.

- Si mi ingreso llegaría a cambiar, dado a pérdida de trabajo, nuevo empleo o recibido de otra fuente, Yo estoy de acuerdo en reportar estos cambios a la clínica en la cual recibo atención médica.
- Yo estoy conciente que no reportar empleo o ingresos de cualquier fuente puede resultar en cargos penales civiles o criminales. También estoy conciente que puedo ser responsable por los cargos médicos de lo servicios recibíos en la clínica en su totalidad.
- Estoy conciente que si soy menor de 19 anos, yo puedo declararme como la cabeza de familia de uno y declarar mis ingresos para los servicios de Planificación de Familia.

SIGNATURES

PRINTED NAME/NOMBRE ESCRITO EN MOLDE	DATE/FECHA
PATIENT SIGNATURE/FIRMA DE PACIENTE	WITNESS SIGNATURE/FIRMA DE TESTIGO

Sacred Heart Community Clinic Patient Health Information Date________________

Patient Name____ Date of Birth______________

What is the one concern you are here to be seen for today? ______________________________

On any medicines currently? What dose? How many times a day? How long have you been on it?

____________	______	________	____________
____________	______	________	____________
____________	______	________	____________
____________	______	________	____________
____________	______	________	____________

Are you allergic to any medicines? What type of reaction?

____

____

Are you allergic to latex (balloons, rubber gloves, etc.)? ____________________

Do you have any food or nut allergies? ______________________________________

Have you been hospitalized in the past or had surgery? When? Reason?

____

____

Any ongoing medical problems? ______________________________________

____

Major medical problems in your family? Who? ______________________________

____

____

Do you smoke/what do you smoke? ____________________ How many per week?__________

Do you drink alcohol/what? ________________________ How much per week? __________

Office use only: Info in EMR ______