***Fountain Clinic***

REGISTRATION

**PLEASE PRINT**

**DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LAST FIRST MIDDLE**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street City State Zip County**

**PHONE: ( ) SOCIAL SECURITY #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sex: Male\_\_\_\_\_\_ Female\_\_\_\_\_\_\_ Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_**

**Employment: Yes\_\_\_ No\_\_\_ Full-Time\_\_\_ or Part-Time\_\_\_**

**Employer Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Monthly Household Income:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Source of Household Income:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Did you file income tax last year? \_\_\_\_\_\_\_\_\_\_\_(*We will need a copy before making further* *appointments)***

**Do you have health insurance? Yes or No (circle one)**

**If yes is it: Medicaid Medicare Commercial Insurance (circle one)**

**KNOWN DRUG ALLERGIES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have a regular physician? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_**

**If yes, please provide physician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When did you last see the Doctor?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name Phone#**

**Are you a Veteran? Yes\_\_\_ or No\_\_\_**

**Highest level of education completed: Some High School\_\_\_ High School\_\_\_ Some College\_\_\_**

**College\_\_\_**

**Race/Ethnicity: White\_\_\_\_\_ African American\_\_\_\_\_ Asian\_\_\_\_\_ Native American\_\_\_\_**

**Hispanic\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_**

**How many in household? Children under 18\_\_\_\_\_\_ Adults\_\_\_\_**

**Marital status: Single\_\_\_\_\_ Married\_\_\_\_\_ Divorced \_\_\_\_\_ Widowed\_\_\_\_\_**

**Persons living in your household: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Living Arrangements: *(circle one)* Own or Rent - Live w/Friends or Family Homeless\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about the Fountain Clinic & its services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**A $5 MINIMUM DONATION IS ASKED FROM ALL PATIENTS FOR FOUNTAIN CLINIC SERVICES SO THAT WE MAY CONTINUE SERVING OUR UNINSURED COMMUNITY. THANKS!**

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**