

WILLING HELPERS MEDICAL CLINIC - NEW PATIENT APPLICATION

Please put a check mark by the documents you will provide for intake

Proof of Identification (choose one)

- Driver's License or State ID
- Passport

Proof of Residency (choose one)

- Current Utility Bill
- Current Telephone Bill
- Current Car Insurance Bill Current Bank Statement Other
(Hospital bills do not count as proof of residency.)

Proof of Income (choose one)

- Income Tax W2 or 1099 form
- Current Payroll check stubs for 30 days of work
- Disability Award Letter
- Wage statement for no income from the Department of Labor
- A letter of support is needed if the applicant is not employed (available on our website)
- If married, both you and your spouse will need to provide proof of income from the choices above

We are a 100% donation-funded healthcare facility. To continue providing high-quality healthcare services, we invite you to make an optional \$10 donation at each visit. This donation is not required and will not affect your ability to receive care. All contributions help us continue to serve our community. Thank you for your support!

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Date: _____

SSN: _____

Birth Date: _____

Name: _____

Sex: Male Female

Address: _____

Best Phone Number: _____ Email: _____

Emergency Contact Name: _____ Phone: _____

Single Married Divorced Separated Widowed

Race: American Indian or Alaska Native Middle Eastern or North African Asian White

Native Hawaiian or Other Pacific Islander Black of African American Hispanic or Latino

Preferred Language: _____ Sexual Orientation: _____

Preferred Pharmacy: _____

Do you need an interpreter? No Yes - What language? _____

How did you hear about us: Google PCP Referral Specialist Referral Word of Mouth

Hospital Current Patient Insurance Company Other _____

Why are you here today (What is your main medical problem): _____

What other doctors do you see? _____

Last time you saw a doctor: _____ Last time in hospital _____ Why: _____

SOCIAL HISTORY:

Exercise: Yes or No How often? _____

Nicotine Use? Yes or No How Much _____ Vaping Use? Yes or No

Alcohol Use? None Occasional Moderate Heavy

Substance Use? Yes or No Marijuana Meth Cocaine Heroin Other

Caffeine? None Occasional Moderate Heavy

Transportation: I have a car that works No car / broken Have help Do NOT have help

Have you applied for disability? Yes or No Have you applied for Medicaid? Yes or No

Food: Have enough Don't have enough Have food stamps Use food pantries

Are you a spiritual person? Yes or No. If yes, are you where you want to be spiritually? Yes or No

How can we help you reach your spiritual goals? _____

Special Needs: Yes or No Reading Vision Hearing Mobility Speech Language

Sleep: Hours per night _____ Trouble sleeping: Yes or No Snore: Yes or No

Utilities: I have water and electricity where I live I do NOT have water or electricity

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VACCINATIONS:

| | | | | | |
|------------------|-----------|--------------|--------------|-----------|--------------|
| | | Approx Date: | | | Approx Date: |
| Tetanus | Yes or No | | Flu | Yes or No | |
| Hepatitis | Yes or No | | Covid | Yes or No | |
| Pneumonia | Yes or No | | | | |

SURGERIES:

| TYPE OF SURGERY | WHEN |
|------------------------|-------------|
| | |
| | |
| | |
| | |

ALLERGIES: _____

FAMILY MEDICAL HISTORY:

| RELATIVE | AGE | DISEASES | LIVING | CAUSE OF DEATH |
|-----------------|------------|-----------------|---------------|-----------------------|
| Father | | | | |
| Mother | | | | |
| Sister | | | | |
| Brother | | | | |
| Other | | | | |

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MEDICAL HISTORY:

| | | | | | |
|---|-----|----|------------------------------------|-----|----|
| AIDS/HIV | Yes | No | Heart Disease | Yes | No |
| Anemia | Yes | No | Heart Failure | Yes | No |
| Arthritis | Yes | No | Heartburn/Reflux/GERD | Yes | No |
| Asthma | Yes | No | Hepatitis B | Yes | No |
| Back Pain | Yes | No | Hepatitis C | Yes | No |
| Bipolar | Yes | No | High Blood Pressure | Yes | No |
| Blood Clots | Yes | No | High Cholesterol | Yes | No |
| Bronchitis | Yes | No | Hypertension | Yes | No |
| COPD | Yes | No | Hyperthyroidism/ Hypothyroidism | Yes | No |
| Cancer | Yes | No | Irritable Bowel Syndrome | Yes | No |
| Chest Pain | Yes | No | Kidney Disease | Yes | No |
| Cirrhosis/Liver Disease | Yes | No | Kidney Stones | Yes | No |
| Congestive Heart Failure | Yes | No | Leg Pain | Yes | No |
| Depression/Anxiety | Yes | No | Mental Disorder | Yes | No |
| Diabetes | Yes | No | Numbness | Yes | No |
| Fainting | Yes | No | Panic Attacks | Yes | No |
| Frequent Headaches | Yes | No | Pneumonia | Yes | No |
| Frequent UTI | Yes | No | Pulmonary Embolism | Yes | No |
| Gallstones | Yes | No | Seizure | Yes | No |
| Glasses / Contacts | Yes | No | Severe Dizziness | Yes | No |
| Gout | Yes | No | Skin Cancer | Yes | No |
| Hearing Loss | Yes | No | STI/STD | Yes | No |
| Heart Attack/Coronary Artery Disease | Yes | No | TIA/Stroke | Yes | No |
| | | | Ulcer | Yes | No |

WILLING HELPERS MEDICAL CLINIC - NEW PATIENT APPLICATION

Willing Helpers Medical Clinic Patient Rights and Responsibilities

Patient **RIGHTS** include:

- The right to be treated with respect and dignity at all times.
- The right to ask questions, voice concerns, and participate in decisions regarding plans of treatment.
- The right to clear, concise explanations of techniques, procedural risks, possible outcomes, and the probability of success.
- The right not to be subjected to any procedures without giving voluntary, competent, and informed consent.
- The right to express feelings of discomfort about sharing medical issues with any staff member during clinic visits.
- The right to privacy and confidentiality regarding both personal and informational data as it pertains to healthcare.
- The right to have cultural, psychosocial, spiritual, and personal values, beliefs and preferences respected and be free from all forms of abuse, neglect, exploitation, or harassment.

Patient **RESPONSIBILITIES** include:

- The responsibility to complete the clinic enrollment application before receiving medical treatment.
- The responsibility to provide advance notification if unable to keep a scheduled appointment at the clinic or at a specialist office that you were referred to by the clinic. Appointments should be cancelled no later than noon the day before the appointment.
- The responsibility to inform the clinic staff of changes to contact information (address, phone number, income, insurance coverage) in a timely manner.
- The responsibility to provide a complete report of all medications that he or she is taking at the time of each clinic visit, including strength, dosage, and frequency. (Bring all medication bottles to each visit).
- The responsibility to notify the clinic at least one week prior to needing refills on medications
- The responsibility to comply with all clinic policies and procedures.
- The responsibility to comply with the treatment regimen.
- The responsibility to follow through with diagnostic tests and procedures within the prescribed time frame.
- The responsibility to refrain from abusive language and behavior.
- The responsibility to report unexpected changes in medical condition to the practitioner.

Failure to comply with any of the above could result in loss of clinic privileges. Noncompliance will be documented in the patient's chart and will be reviewed by the Clinic Manager and/or Executive Director after three noncompliance entries.

Patient Signature: _____

Printed Name: _____

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**Willing Helpers Medical Clinic Appointment Cancellation/
No-Show/Late Arrival Policy**

Thank you for trusting your medical care to Willing Helpers Medical Clinic.

When you schedule an appointment with Willing Helpers Medical Clinic, we set aside enough time to provide you with the highest quality care.

Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

If you will be more than 15 minutes late for an appointment, please contact the office to notify us and ensure that you can still be seen that day.

Please see our Appointment Cancellation / No-Show Policy below:

- Effective May 1, 2019, a note will be made in the chart of any established or new patient who fails to show or cancel/reschedule an appointment without at least a 24-hour notice.
- Any established or new patient who fails to show or cancels/reschedules an appointment without 24 hour notice for the third time in a rolling year will be dismissed from Willing Helpers Medical Clinic and will not be rescheduled.
- Any established or new patient who is more than 15 minutes late for a scheduled appointment for the third time in a rolling year will be dismissed from Willing Helpers Medical Clinic and will not be rescheduled.
- Willing Helpers Medical Clinic does attempt to remind patients of their visits by phone or email. However, even if you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment.

If you should experience extenuating circumstances, please contact the clinic as soon as possible. You may leave messages with Willing Helpers Medical Clinic 24 hours a day, 7 days a week at 678-625-8317 or at info@willinghelpersclinic.com.

I have read and understand the Medical Appointment Cancellation / No-Show Policy and agree to its terms.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

