REQUIREMENTS FOR BECOMING A PATIENT

1. Applicant cannot have any health insurance (including Medicaid and Medicare).
2. Be between the ages of 14-64
3. Be a resident of Mecklenburg or Union County for at least 3 months.
5. Bring a fully completed application with photocopies of all of the required documents (listed on page 2 of this application packet) to a new patient screening. Please call Matthews Free Medical Clinic at 704-841-8882 ext. 100 to confirm the date and time of our next New Patient Screening. The day of screening, there is no appointment needed. Applicants will be screened in the order that they sign in.
6. Please note that if you are applying for any other family member, they must meet requirements and each applicant must complete an individual application and bring supporting documents.
7. Application processing time is dependent on receiving all of your medical records from previous medical providers. Please note that, delays in receiving records will result in delay in processing your application.
8. If accepted, please note that new patients will be dismissed immediately if they fail to show up for their first appointment.

By signing this patient agreement, I acknowledge that the contents of this application are true to the best of my knowledge and agree to comply with the Clinic's policies. This application does not guarantee medical services. Your information is kept confidential and will not be shared without your permission.

Applicant’s signature __________________________________________ Date __________________________

Applicant/Authorized representative*

*If Authorized Representative, please indicate relationship to patient:

_____ Spouse _____ Parent _____ Other (Please specify) ________________________________
NEW PATIENT APPLICATION REQUIRED MATERIALS

Applicant Name: ___________________________ Date: ________________

(Please Print)

Please be sure to include the following information with your application. Bring 1 copy of each document. Copies can be made at the clinic for $0.25/page if necessary. Only completed applications with copies of the required documents can be processed.

____ Copy of Social Security card for applicant (if applicable)

____ Copy of valid picture identification for applicant (driver’s license, passport, etc.)

____ Proof of earned income (including spouse’s proof of earned income, if applicable):

☐ Copy of current year tax return
☐ Copy of two most recent, consecutive paystubs for applicant OR a letter from employer on company letterhead about rate of pay per hour and number of hours per week worked for the past month for applicant (if paid in cash).
☐ For Self-Employment income, provide current business tax return (if applicable) and copies of past three month’s business and personal bank statements. If you have any questions about Self-Employment proof of income requirements, please contact the clinic.

____ Copy of Food Stamps card or yearly acceptance letter

____ Copy of 2 most recent, consecutive Checking and Savings Account Statements (full statements)

____ Copy of one utility bill (or piece of mail) reflecting name and address of applicant with current date

____ Medicaid denial letter, if applicable

____ Proof of additional income:

☐ Child Support ___________________________
☐ Social Security Income (SSI) ___________________________
☐ Unemployment Benefits ___________________________
☐ Workman’s Compensation Benefits ___________________________
☐ Housing Assistance Letter
☐ Letter of Support. (If you have income please tell us how your household bills are paid. If another person pays the bills, please provide a signed letter(s) of support.
☐ Disability (SSDI)
☐ Other
Matthews Free Medical Clinic

NEW PATIENT APPLICATION

Last Name __________________ First Name __________________  MI __________________

Social Security #: __________________

Gender (Circle): Female  Male

Birth Date (mm/dd/yyyy) ____________  Age ____________  Race __________________

Street Address __________________ PO Box (mailing only) __________________

City __________________  State __________________  Zip Code __________________

(_____) __________________ (_____) __________________ (_____) __________________

Preferred Phone  Alternate Number  Interpreter’s Phone Number

Primary Language: __________________  Needs Interpreter (Circle): Yes  No

Housing:

☐ Own  ☐ Rent  ☐ Community Shelter  ☐ Staying with Family/Friends

☐ Homeless  ☐ Other

Marital Status:

☐ Single  ☐ Married  ☐ Divorced  ☐ Widow(er)

☐ Separated  ☐ Civil Union

County (Circle): Mecklenburg  Union

Length of time in County: _______ yrs. _______ months  Immediate Family Members Living in Household: __________________

Do you work (Circle)?  Yes  No  If yes, where? __________________ For how long: __________________

If no, where did you last work and when? __________________

Do you currently have health insurance?  Yes  No

Have you applied for or had Medicaid/Medicare?  Yes  No  If yes, what type & when: __________________

Have served/retired in the US Military?  Yes  No

Have you been convicted of a felony?  Yes  No  If yes, what was the charge: __________________

Have you been seen by any medical facilities/providers within the last five years, including Behavioral Health centers?  Yes  No

** List ALL you have seen, when, where and why? __________________

____________________________  ________________________________  ________________________________

Emergency Contact Information:

Name: __________________ Relation: __________________ Phone: __________________

Name: __________________ Relation: __________________ Phone: __________________
**List Family Members** (Only spouse and children, if applicable)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Relationship</th>
<th>DOB mm/dd/yy</th>
<th>Sex F / M</th>
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*I certify that to the best of my knowledge, all statements are true and correct.*

**Applicant’s Signature**

**Date**
LETTER OF SUPPORT

Date: __________________________

I, ______________________________ (name of person providing support), provide support in the following way(s) (circle all that apply): pay rent pay utilities other___________________________

for ______________________________ (person being supported). I provide support in amount of $______________________________ per month (dollar value of support).

Printed Name __________________________ Signature __________________________

Relationship to Patient __________________________ Phone Number __________________________

*IF MORE THAN ONE PERSON IS SUPPORTING YOU, YOU WILL NEED TO GET A LETTER OF SUPPORT FROM EACH ONE.*

STATEMENT OF NO INCOME:

If you have no monthly income, please read and sign the following statement.

I, ______________________________ do not currently have any income, which includes but is not limited to, wages, unemployment benefits, disability benefits, self-employment income, Social Security and retirement. I understand that it is my responsibility to report to Matthews Free Medical Clinic the start of any income within 10 days of its beginnings.

IT IS VERY IMPORTANT ALL INCOME INFORMATION IS PROVIDED. PROVIDING THIS INFORMATION DOES NOT AUTOMATICALLY DISQUALIFY YOU AS A PATIENT. INCOME GUIDELINES ARE BASED ON FEDERAL POVERTY LEVELS.

By signing this document I am agreeing that all of the information is accurate to the best of my knowledge.

Signature: __________________________ Name: __________________________ Date: __________________________
# HEALTH HISTORY

**Name:** ___________________________ **DOB:** ___________________________

**Last**  **First**  **MI**

**Why would you like to make an appointment with the doctor? (Describe Problem(s))**

________________________________________

**List current medications (dose & frequency): (Write N/A if not on any medications)**

________________________________________
________________________________________
________________________________________
________________________________________

(If there are more, list on a separate attached sheet.)

**List any medications you are allergic to & the reaction you experienced (write N/A if none):**

________________________________________
________________________________________
________________________________________
________________________________________

**List all other allergies:**

________________________________________
________________________________________
________________________________________
________________________________________

**List all over the counter or herbal medication or supplements that you take on a regular basis (write N/A if none):**

________________________________________
________________________________________
________________________________________
________________________________________

**List all previous hospitalization and surgeries**

<table>
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<th>Date</th>
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</table>

**Social History ** provide accurate information **

1. **Do you smoke? (Circle One)**  Yes  No  Previously
   If yes, how many packs per day _______ and for how many years? _______.

2. **Do you drink alcohol? (Circle One)**  Yes  No  Previously
   If yes, how many drinks per day _______ and how many drinks per week? _______.

3. **Do you use street drugs? (Circle One)**  Yes  No  Previously
   If yes, what kind? ________________ and have you ever shared needles? ____ Yes ____ No
*** Please check all that apply to YOUR previous or current health ***

GENERAL:
- □ Weight change in the last year
  - Increase by __________
  - Decrease by __________
- □ Accident, injury or illness not listed above: ____________________________
- □ Unusual Childhood Illness: ____________________________
- □ Recent travel outside the USA: ____________________________

CARDIOVASCULAR:
- □ Heart attack/angina
- □ Chest pain
- □ Palpitations/irregularities
- □ High blood pressure
- □ Heart murmur
- □ Rheumatic fever
- □ Valve problem
- □ Poor circulation
- □ Varicose Veins/blood clots
- □ Thrombophlebitis
- □ Other:

PULMONARY:
- □ Unexplained shortness of breath
  - At night?
- □ Pneumonia
- □ Chronic bronchitis
- □ Emphysema
- □ Asthma
  - Date of last attack? __________
- □ Cough
- □ Blood/blood tinged cough
- □ Sinus condition
- □ Hay fever
- □ Other:

ENDOCRINE:
- □ Diabetes
- □ Thyroid condition
- □ Cortisone treatment
- □ Obesity
- □ Other:

RHEUMATOLOGY:
- □ Stiff or swollen joints
- □ Back pain
- □ Sciatica
- □ Bursitis
- □ Arthritis, rheumatism, or gout

INFECTIOUS DISEASE:
- □ Serious infection
  - What: __________________________

GASTROINTESTINAL:
- □ Nausea/vomiting
- □ Diarrhea
- □ Constipation
- □ Recent change in bowels
- □ Ulcers
  - When: __________________________
- □ Yellow jaundice
- □ Hepatitis
- □ Gall bladder disease
- □ Pancreatitis
- □ Heartburn/indigestion
- □ GI bleeding
- □ Bloody stool
- □ Black tarry stools
- □ Oily/clay colored stools
- □ Hemorrhoids
- □ Abdominal pain
- □ Bloating/gas pains
- □ Hernia
- □ Colitis/spastic colon
- □ Diverticulitis
- □ Other:

NEUROLOGICAL:
- □ Headaches:
  - Migraine □
  - Tension □
  - Sinus □
- □ Seizure disorder
- □ Neuritis/neuralgia
- □ Meningitis/polio
- □ Stroke
  - Date? __________________________
- □ Dizzy spells/blackouts
- □ Vertigo
- □ Weakness/numbness in extremity
- □ Unconsciousness
- □ Nervousness
- □ Vision problem
  - Date of last exam: __________________________
- □ Hearing problem
- □ Other:

MUSCULO-SKELETAL:
- □ Previous history of fracture
- □ Osteopenia or Osteoporosis
- □ Joint surgery

MISCELLANEOUS:
- □ Depression

□ Increased pressure from work, spouse, family
□ Crying spells
□ Insomnia
□ Extreme weakness/tiredness
□ Pre-existing mental health condition: __________________________
□ Changes in skin
□ Other:

GENITO-URINARY:
- □ Kidney damage
- □ Kidney stone
- □ Bladder infection(s)
- □ Blood in urine
- □ Frequent urination
- □ More than 1 urination at night
- □ Albumin, pus, protein in urine
- □ Venereal disease
- □ Discharge from penis
- □ Swollen testicle
- □ Prostate trouble
- □ Other:

MENSTRUAL HISTORY:
- □ Onset of menses: __________________________
  - Date of last period: __________________________
  - Length of period: __________________________
- □ Number of
  - Pregnanacies: ___ Miscarriages: ___ Abortions: ___
- □ Pregnancy complications: __________________________

□ Menstrual irregularity
□ Severe cramps
□ Mental tension before/during periods
□ Decreased flow
□ Flooding
□ Spotting/discharge
□ Other:

HEMATOLOGY/ONCOLOGY:
- □ Bleeding disorder
- □ Anemia
- □ Easy bruising
- □ Enlarged lymph nodes
- □ Cancer/tumor
- □ Other:

PREVIOUS TREATMENT:
- □ Special Diet
- □ Blood thinners
- □ Tranquilizers
- □ Vitamins
- □ Frequent laxatives
- □ Birth control pills
- □ Treatment for alcoholism
- □ Treatment for drug use
- □ Other:

Last name: __________________________
<table>
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<tr>
<th>CONDITION</th>
<th>YES</th>
<th>BLOOD RELATIVE/RELATIONSHIP</th>
<th>CONDITION</th>
<th>YES</th>
<th>BLOOD RELATIVE/RELATIONSHIP</th>
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<tbody>
<tr>
<td>Anemia</td>
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<td>High blood pressure</td>
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<td>Arthritis</td>
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<td>Thyroid (Hypo or hyper)</td>
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<td>Asthma</td>
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<td>Hepatitis</td>
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<td>Bladder Infection</td>
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<td>Headaches or migraines</td>
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<td>Blindness</td>
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<td>Heart Attack</td>
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<td>Bronchitis</td>
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<td>Heart Failure</td>
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<td>Cataracts</td>
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<td>Kidney infections or stones</td>
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<td>Cirrhosis of the liver</td>
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<td></td>
<td>Seizures</td>
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<td>Diabetes: Non-insulin dependent</td>
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<td>Sexually transmitted diseases</td>
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<td>Anxiety</td>
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Family History: Please write "yes" in the "yes" column if a blood relative has ever been treated for the listed condition and then provide the nature of the relationship. For example: grandfather, uncle, sister, etc.
Matthews Free Medical Clinic

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient’s Name: ___________________________________ Date of Birth: ______________________

Patient’s Address: ________________________________________________________________

Information to be released FROM (to get records from your previous health care provider)

Facility and/or Doctor’s Name: ______________________________________________________

Address: ________________________________________________________________

__________________________________________________________

Phone: ___________________________________ FAX: __________________________

Date of services requested: From_________________________ To_________________________

Check information to be released (used or disclosed):

☐ Office notes ☐ Radiology reports/imaging x-rays
☐ Laboratory/pathology reports ☐ EKG/monitors
☐ Other (specify) __________________________

Check purpose of disclosure:

☐ Medical review ☐ Legal Review
☐ Personal use ☐ Other (specify) __________________________

Information to be released TO: MATTHEWS FREE MEDICAL CLINIC

196 S. Trade Street, Matthews, NC 28105
Phone: 704-841-8882 Fax: 704-841-8879

Will the health care provider requesting the authorization receive any financial or in-kind compensation in exchange for using or disclosing the health information described above (Circle one): Yes No

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV). I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the providing organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this private health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Printed Name: ___________________________ Signature: ___________________________ Date: __________

(Patient/Authorization Representative)

Please note, if information relating to the treatment of drug or alcohol abuse is being released, for a patient under the age of 18, the patient must also sign this authorization.

Minor Signature: ___________________________