Fountain Clinic

REGISTRATION

PLEASE PRINT

DATE_____

NAME: _____
LAST **FIRST** **MIDDLE**

ADDRESS: _____ _____
Street **City** **State** **Zip** **County**

PHONE: (**)** _____ **SOCIAL SECURITY #**_____

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:_____

Emergency Contact: _____
Name **Phone#**
Do you have a regular physician? Yes_____ **No**_____
If yes, please provide physician's name: _____
When did you last see the Doctor?_____

Are you a Veteran? Yes___ **or No**___
Highest level of education completed: Some High School___ **High School**___ **Some College**___
College___
Race/Ethnicity: (Optional) White_____ **Black/African American**_____ **Asian**_____ **Native American**____
Hispanic/Latinx_____ **Other**_____ **Multi-Racial**_____
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:_____