Good Neighbor Free Medical Clinic of Beaufort

New Patient Registration Form

Instructions: **Complete all parts of this form. Please answer all questions.**

When completed, GNMC staff will go over it with you to help fill in any blanks and to let you know what you need to do to schedule an appointment to see one of our clinicians.

Today's Date: ___/___/___

Who referred you to the Clinic? _____

Part 1 – General Information

Name: _____DOB: _____ SS#:_____-____-_____

Physical Address: _____ Mailing Address (if different from physical address):

_____ _____

_____ _____

Home phone: (____) ____-_____ Work Phone: (____) ____-_____ Cell Phone: (____) ____-_____

Email Address: _____

Gender: Male__ Female __
Race/Ethnicity: Black__ White__ Hispanic__ Asian__ Native-American__ Other_____
Marital Status: Single__ Married/Partnered__ Widowed__ Divorced__ Separated__

Part 2 – Family and Household

Name of spouse or significant other: _____ DOB: ___/___/_____

Do you have children? Y___ N___

Name	Lives with me	DOB
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency Contact

Name:_____

Address:_____

Relation: _____ Phone: (___) ___-____

Alternate Contact

Name: _____

Address: _____

Relation: _____ Phone: (___) ___-____

Part 3 – Religious/Spiritual Information

We provide medical care to all patients without regard to their religious beliefs. We offer spiritual support to those who wish to receive it. If you would like to meet with a GNMC pastoral care volunteer, please ask.

Part 4 – Lifestyle Information

Highest level of education: _____Veteran? Y __ N __
Do you exercise? Y__ N__ What? _____ How often? _____
Do you feel supported by your family, friends, church, other group? _____

Part 5 – Health Information

Previous healthcare provider (***not*** ER)?_____
Date of last visit? _____ Reason for visit?_____
When was your last visit there? _____ for what reason? _____

What other health professionals have you seenin the last year (e.g., physical therapy, mental health, other)?_____

Do you take prescription medications? Y __ N__ If yes, please bring all medications to your screening visit.

How many times have you been to the ER in the last month? __in the past year? __ Date of last visit: ____

What is the most common reason you've gone to the ER? _____

Would you like to attend diabetes education classes at the Clinic? Y__ N__

Do you have an AccessHealth card? Y__ N__

Please let us know any other information that might help us provide better care for you.

Part 6 – Employment Information

Are you employed?Yes: Temporary__Part-Time__ Full-Time__Self-employed__

Occupation: _____ Length of Employment: _____Salary: $_____

If not employed, reason: Student__ Laid off__ Disabled__Other: _____

Part 7 – Financial Information - Monthly

Household Income:	**Household member**	**Source**	**Amount**	**Food Stamps/Housing**
	Name:_____	_____	$_____	_____
	Name:_____	_____	$_____	_____
	Name:_____	_____	$_____	_____
	Name:_____	_____	$_____	_____

I certify that all information provided is correct.
Date:__/__/__ Patient Signature: _____

I have reviewed the information with the patient.
Date:__/__/__ GNMC Staff Signature: _____