

Hannibal Free Clinic

Quality Healthcare-Caring Volunteers

PATIENT APPLICATION

Last Name First Name Middle Name Maiden Name

Date of Birth Social Security# Other names may be used on records

Street Address City State Zip

Home Phone Cell Phone Contact Phone

Notify in case of Emergency Relationship Emergency Phone

List household members

List all household members (Including Self)	Relationship	Monthly Income	Income Source	Disability Yes/No
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
Total in Household =		Total Income		

Please check all sources of Income and Benefits for your Household. Please bring copy of recent payroll stub with year to date totals, last year's tax return, and any award letters when you return application.

This will help the clinic staff if you need to have additional care thru another agency and also speed access to medications thru patient assistance programs.

Savings Unemployment Social Security Veterans Benefits
Child Support Pension SSI Settlements
Employment Other _____

Employer City State Phone

What health problems do you need to have treated at the clinic? _____

How did you hear about the HANNIBAL FREE CLINIC? _____

Marital Status: Single Married Divorced Widowed Separated

Male Female Race _____ Religion _____

Are you a veteran? ___Yes ___No Have you filed for disability? ___Yes ___No

Please list where you have previously received medical treatment and contact information and approximate dates of service if available. This will allow us to obtain your old records prior to your appointment.

Physician/Clinic City State Phone Dates

Physician/Clinic City State Phone Dates

Hospital City State Phone Dates

Hospital City State Phone Dates

Other City State Phone Dates

Other City State Phone Dates

I, _____, hereby authorize the above named parties to release information to the HANNIBAL FREE CLINIC, 711 Grand Ave, Hannibal, MO 63401.

I understand the information released may include, but is not limited to: history, diagnosis and/or treatment of drug and alcohol abuse, mental illness, or communicable disease including human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). I authorize the release of these specific data. I understand this authorization will expire one year from the date of my signature or on ___/___/___ (DD/MM/YYYY). I understand I may revoke this authorization at any time by notifying the providing organization in writing, but if I do not revoke this authorization it won't have any affect on any actions taken before they receive the revocation. I understand I may be charged for copies of my medical records. I have read the above information and authorize the above mentioned organizations to release the identified information to the HANNIBAL FREE CLINIC. I understand by signing this document, I release the healthcare facility from any liability for any release made as a result of the authorization.

Signature of patient or patient's representative Date

Please return completed application to 711 Grand Ave Hannibal, MO 63401 or fax to 573-248-8350 or call 573-248-8307 with questions.