PATIENT APPLICATION

Please complete and attach any of the financial documents listed below that apply to you:

1. South Carolina Driver's License or South Carolina Photo ID

2. Social Security card.

3. Current Federal 1040(IRS) Income Tax Return. (If no tax return, current pay stub).

4. Social Security benefit letter, disability benefit letter or retirement/pension income letter.

5. If no income, please write a statement explaining how monthly needs are met. (If living with someone, have them write a statement).

If you need help completing application please ask or call (843-347-7178) Monday – Thursday. We want to help you receive medical care and medications.

Recipient of 2007 SC Secretary of State Angel Award: 1 of the top 10 charities in SC

Horry County's Only Free Medical Clinic and Pharmacy Since 1965   Committed to Low Income Adult Residents

UNITED WAY COMMUNITY PARTNER

(843) 347-7199 FAX 347-7180   1396 Highway 544   Conway, South Carolina 29526

PATIENT PROFILE

Last Name:______________________ First Name: ____________________________ MI________

Address where you live: ________________________________City __________________Zip Code_______

Mailing Address: ____How long in Horry County? ____Yrs. Mo._____

Home Phone: (___)______-_______ Cell: (____)_______-________ SS# _____________-_____-________________

Date of Birth: _______________ Sex: 0 Male 0 Female Auto: Make _____________ Model __________ Yr._____

Referred BY: 0 Access Health, 0 Friend, 0 Social Services, 0 Word of mouth, 0 Hospital, 0 Lawyer, 0 Care Team,

0 Other:______________________________________ #Adults in household _____ #kids under age 18 _____

Allergic to Medications: 0 Yes 0 No Do you have medical insurance? 0 Yes 0 No

Employer: ________________________ If not working, why? ____

Are you a US citizen? 0 Yes 0 No Green Card? 0 Yes 0 No Are you a veteran? 0 Yes 0 No

Race/Ethnicity: 0 African American, 0 Bi-Racial, 0 White, 0 Asian, 0 Hispanic, 0 Native American, 0 Other ________

Have you been convicted of a crime? 0Yes 0 No List charge(s)______________________________________

Marital Status: 0 Married, 0 Single, 0 Divorced, 0 Widowed, 0 Legally separated, 0 Separated

Housing: 0 Own, 0 Rent, 0 Stay with family or friend, 0 Section 8 Housing, 0 Other_________________

Emergency Contact: Name ___________________________________ Phone______________ Relationship____________

MONTHLY INCOME SOURCES (including those living with you)

Wages$ ______________ Social Security Disability for Patient $_____________ Disability Start Date _____Mo. ______ Yr

VA Benefits $__________ Social Security $___________ SSI $ _________ Workman's Comp $ _____________

Retirement/ Pension $_________ Section 8 Housing and Utilities $ _______ Unemployment Amount $____________

Other Income and from where $__________________________________

Total Monthly Household Income $__________________

<u>Your Application can not be processed until everything is submitted</u>

<u>DO NOT RETURN WITHOUT FINANCIAL DOCUMENTS ATTACHED</u>

Patient signature ____ *Date* ____________

Screener Signature ____ *Date* ____________

Revised 5-2018

(Confidential)

Patient Name________________________ Today's Date__________

Age________ Birthdate______________ Date of last physical examination__________

What is your reason for visit?______________________________

Symptoms

Check (✓) symptoms you currently have or have had

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period__________

Date of last Pap Smear__________

Have you had a mammogram?__________

Are you pregnant?__________

Number of children__________

Conditions

Check (✓) conditions you currently have or have had

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Medications

List medications currently taking or have taken within a year

____

____

____

____

Allergies

____

____

____

____

complete back side ←

Health History (OVER) →

Family History

Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following:

	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates ____________

Serious Illness/Injuries	Date	Outcome

List Doctors & Clinics that have your MEDICAL RECORDS | PHONE #

1)
2)
3)
4)

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to the following:

	Stress		Hazardous Substan
	Heavy Lifting		Other

Occupation ____________

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ____________ Date ____________

AUTHORIZATION FOR RELEASE—RETRIEVAL OF INFORMATION

CONSENT FOR CARE: STATE OF SOUTH CAROLINA ACKNOWLEDGEMENT OF MEDICAL SERVICES WITHOUT COMPENSATION

INDIGENT PATIENT PROGRAM MEDICATION LIMITED POWER OF ATTORNEY

The administration of **Friendship Medical Clinic and Pharmacy** believes that the most comprehensive care can be afforded to its patients by the sharing of information between itself and various physician's offices, agencies, SCHIEx and companies. Relevant biographical, financial information and medical records may be shared with other agencies to better find the appropriate standard of care and/or treatment. Medical history, labs, **(may include a HIV or Hepatitis C test)** x-rays, medical condition, physician notes and any other medical material will be requested from all medical facilities where you have been treated.

At times, it becomes necessary to release this information to various referral physicians and agencies. If the **Friendship Medical Clinic** is attempting to seek services for a patient at an outside office, they may need certain information (age, insurance, medical conditions, medical records, labs, and x-ray reports and any other medical information) before agreeing to see the patient.

I am asking for care at this facility. I agree to receive medical services voluntarily and without compensation, expectation, or promise thereof'; these medical services will be rendered by physicians volunteering their service associated with **Friendship Medical Clinic**. I agree tc permit the physician and other caregivers associated with **Friendship Medical Clinic** to treat me in ways they judge beneficial to me. I understand that this care may include tests, examinations medical and/or surgical treatment. No one has given me any guarantee how these examinations and treatments will affect my condition or me. **This acknowledgment or agreement has been made prior to the rendering of medical services by the physician.**

The **Friendship Medical Clinic** receives a portion of its medicines through direct shipments from the pharmaceutical manufacturers Indigent Patient Programs. To request these medicines, the **Friendship Medical Clinic** must prove that our clients cannot purchase them outside the clinic. This requires the **Friendship Medical Clinic** to furnish certain biographical and financial information (size of household, income, social security numbers, etc.) before the medicines are shipped. The forms that we are required to send to the manufacturer require the patient's signature. To save time, we are requesting your permission to sign your name on these forms. **We are asking you to agree to this limited power of attorney by signing below**. Without these programs, the **Friendship Medical Clinic** would not be able to provide the quantities of medicines that are now available.

I AGREE TO ALLOW FRIENDSHIP MEDICAL CLINIC TO RELEASE INFORMATION THAT I HAVE GIVEN THEM AND ALL MEDICAL INFORMATION TO ANY OUTSIDE AGENCY, SCHIEx OR COMPANY AS LONG AS IT IS IN THE BEST INTEREST OF ME AND/OR THE FRIENDSHIP MEDICAL CLINIC. I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE THIS AUTHORIZATION, THAT IT IS STRICTLY VOLUNTARY. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING, IF I DO, IT WILL NOT HAVE ANY AFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOLCATION, BUT, IN SO DOING, I UNDERSTAND THAT THIS MAY ALSO LIMIT THE RESOURCES/SERVICES AVAILABLE TO ME. THEY MAY ACQUIRE ALL MEDICAL RECORDS AND INFORMATION NEEDED TO BETTER TREAT MY CONDITION. IF THE REQUESTER OR RECEIVER IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AND MAY BE REDISCLOSED. I UNDERSTAND THAT I MAY SEE AND OBTAIN A COPY OF THE INFORMATION DESCRIBED ON THIS FORM, FOR A REASONABLE COPY FEE, IF I REQUEST. I MAY RECEIVE A COPY OF THIS FORM AFTER I SIGN IT IF I REQUEST.
This authorization form is in effect as long as I am a patient at Friendship Medical Clinic & Pharmacy, unless I revoke this form.

____

PATIENT SIGNATURE

____

WITNESS SIGNATURE

In the event of an emergency, illness, or death, I hereby declare the following to be listed as my next of kin. Pertinent medical, biographical and/or financial information can be released to them upon written request from proper authorities. It is my responsibility to notify Friendship Medical Clinic of any changes.

____________________________	________________
Next of Kin	Relationship to patient

____

Signature of Patient

____

Signature of Witness