



# Patient Demographic Sheet

**\*\* PLEASE PRINT \*\***

*All information listed is confidential, and will not be shared with anyone outside of JFMC without your consent.*

**First Name:** \_\_\_\_\_ **Middle Name:** \_\_\_\_\_ **Last Name** \_\_\_\_\_ **Suffix:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zipcode:** \_\_\_\_\_

**County:** \_\_\_\_\_

**What is the preferred way to contact you (circle one)?** Home Phone / Work/ Cell/ U.S. Mail/ E-Mail

**May we leave a message?** Y or N

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Sex: M or F**

**Pager #:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Race:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_ **Ethnicity:** \_\_\_\_\_

**Marital Status, Circle One:** Married    Single    Divorced    Widowed    Separated    Other

**Number of Children:** \_\_\_\_\_ **Number in Household:** \_\_\_\_\_

**Employment, Circle One:** Full-Time    Part-time    Unemployed

**If employed, by what company?** \_\_\_\_\_

**Employer's Address and Phone:** \_\_\_\_\_

**Insurance, Circle All That Apply:** None    Medicare    Medical Assistance    VA    CHIPS    Access

**Veteran:** Y or N    **U.S. Citizen:** Y or N

**EMERGENCY CONTACT:**

**Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Zip:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_ **or** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**ADDITIONAL INFORMATION:**

**Is your visit today in any way related to (circle one if applicable):**

Employment Accident    Auto Accident    Other Accident

**HOUSEHOLD MEMBERS:**

NAME	BIRTHDATE:	RELATION:	SEX: M or F	EMPLOYED: Y or N

**MONTHLY INCOME:**

Please include income from ALL sources for ALL persons living in your household, <u>related or unrelated</u> . Include: child support, alimony, wages (before taxes), social security, rental income, worker’s compensation, unemployment, and pensions. Proof of household income is required. You may be required to apply for Medical Assistance, Medicare, or CHIPS, if eligible.	<b>PATIENT</b>	<b>OTHERS IN HOUSEHOLD</b>
Salary/Wages (per month)	\$	\$
Child Support (per month)	\$	\$
Social Security Retirement (per month)	\$	\$
Social Security Disability (per month)	\$	\$
SSI (per month)	\$	\$
Retirement/Pension (per month)	\$	\$
Unemployment (per month)	\$	\$
Food Stamps (per month)	\$	\$
Rental Income (per month)	\$	\$
Workmen’s Comp (per month)	\$	\$
Veteran’s Benefit (per month)	\$	\$
Investments (per month)	\$	\$
Other (per month)	\$	\$

I declare that the above information is correct, and I agree to notify the Johnstown Free Medical Clinic if any information changes. By requesting care at the Johnstown Free Medical Clinic, I hereby give permission for the volunteer medical staff of the Free Clinic to diagnose and treat me. I understand that all the health professionals at the Free Clinic are appropriately licensed and will observe accepted professional standards of care. I understand, however that all licensed health care professionals who qualify under state and federal regulations are immune from professional liability while volunteering.

**Signature of patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

FOR INTERNET USERS: Please phone **814-534-6242** to schedule an Intake appointment.  
Please bring: proof of income • identification • this form • Patient Health Information form

**Johnstown Free Medical Clinic**  
**340 Main Street**  
**Johnstown, PA 15901**

**OFFICE USE ONLY**

Photo ID – type & number: \_\_\_\_\_ MA Denial letter Received: Y N

Proof of Income Requested: Y N Proof of Income Received: \_\_\_\_\_ Approved: Y N Date: \_\_\_\_\_

Comments: \_\_\_\_\_ Intake Worker Signature: \_\_\_\_\_