JOHNSTOWN FREE MEDICAL CLINIC
SERVING THE LAUREL HIGHLANDS REGION

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, related or unrelated. 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.	**PATIENT**	**OTHERS IN HOUSEHOLD**
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:_____