

Matthews Health Clinic

113 North Ames Street, Matthews, NC 28105

Office: 704-841-8882

Nombre del Paciente: _____ Fecha: _____

(Letra de molde)

Favor asegurarse de incluir la siguiente informacion con la solicitud. Traer el original y 1 copia de cada documento.

Las copias de los originales no se hará en nuestra oficina. El hecho de no llevar la documentación se demora el proceso de solicitud y el tratamiento.

- Copia de la tarjeta de la Seguridad Social (si la tiene) del paciente(s).
- Copia de documento de identificacion con foto.
- Comprobante de ingresos:
 - Declaracion de Impuestos
 - 2 comprobantes consecutivos de salarios recibidos o una carta de constancia del patron, en hoja con membrete de la empresa. con el sueldo por hora y el numero de horas **por semana** trabajadas en el ultimo mes por el paciente(s) (si le pagan en efectivo).
 - Para los ingresos por empleo por cuenta propia, por favor haga una lista de todos los ingresos brutos de los ultimos 3 meses y detalle todos los gastos de negocio de los mismos meses.
- Comprobantes de ingresos no ganados, si son aplicables:
 - Carta de aceptacion de cupones alimenticios
 - Pension Alimenticia de _____
 - Ingresos de la Seguridad Social de _____
 - Beneficios de desempleo de _____
 - Beneficios de Compensacion Laboral de _____
 - Carta de Apoyo de Asistencia de Vivienda
 - Carta de Apoyo
- Copia de cuentas corriente y ahorro bancario de 2 meses consecutivos recientes.
- Copia de todas sus facturas mensuales
- Carta de denegacion de Medicaid
- Carta de su empleador indicando si ofrece seguro medico para el empleado y/o familia, cuando se puede registrar, y si tomara el seguro medico, cuando entraria en vigor?

Traiga su solicitud completa a la siguiente Clinica de Registro que se llevan acabo el segundo y cuarto lunes de la mayoría de los meses de las 10:00am hasta las 11:30am. Su solicitud sera revisada, y si determinamos que usted califica, sera contactado para darle cita.

Le pedimos una donacion de \$10.00 cada vez que tenga cita. Solamente aceptamos dinero en efectivo. Si su situacion económica es precaria, por favor notifique al personal de la clinica. No le negaremos atencion a los pacientes, por falta de dinero.

NOTA: No vemos a pacientes embarazadas.

No recetamos narcoticos.

**INSTRUCCIONES Y REQUISITOS PARA HACERSE PACIENTE
DE MATTHEWS HEALTH CLINIC**

1. No tener seguro medico, Medicaid o Medicare.
2. Debe llenar todas las secciones de la solicitud y traer los formularios llenos con **PRUEBA DE INGRESOS**. Sus ingresos no pueden sobrepasar la suma predeterminada por esta clinica.
3. Debe presentar un documento de identificacion con foto, y si tiene, su tarjeta de Seguridad Social.
4. Reservamos el derecho a determinar quien sera elegible como paciente. Asimismo, reservamos el derecho a despedir un paciente que no acuda a sus citas y/o no cumpla con los reglamentos de la clinica. Razones comunes de despido de pacientes:
 - a. Si no acude a las citas. Requerimos que los pacientes llamen 24 horas antes de las citas si necesita cancelarlas y reprogramarlas.
 - b. El intento de obtener drogas.
 - c. Si el doctor considera que las necesidades del paciente seran mejor atendidas en otro lugar.

Esta clinica es una institucion sin fines de lucro. Los doctores y los enfermeros son voluntarios. Matthews Health Clinic depende de las donaciones de la comunidad, de organizaciones locales y de subvenciones para poder servir a sus pacientes. No esta afiliada a ningun hospital o agencia gubernamental. Nuestros servicios se limitan a cuidados medicos basicos..

Matthews Health Clinic hara todo lo posible por atenderlo, PERO, a pacientes potenciales no se les garantiza o da derecho a servicios especificos.

Firmando este documento usted reconoce que entiende el contenido de este y se compromete a cumplir con los reglamentos de la Clinica. Usted tambien reconoce que toda la informacion que usted ha suministrado es veridica. Su informacion es confidencial y no se divulgara sin su autorizacion..

Firma del paciente _____ Fecha _____
Paciente/Representante Autorizado*

Entiendo que Matthews Health Clinic opera bajo un limite de disponibilidad. Es imposible que los doctores y el personal esten disponibles 24 horas del dia, 7 dias por semana. Si yo alguna vez tuviera una emergencia medica, llamare al 911 o ire a la sala de emergencia mas cercana. Si necesito ayuda medica que no es de emergencia cuando la clinica esté cerrada, buscare otras opciones medicas como en un centro local de salud.

Firma del paciente _____ Fecha _____
Paciente/Representante Autorizado*

*Si es el Representante Autorizado, por favor indique su relacion con el paciente:

_____ Esposo/a _____ Padre _____ Otro (especifique)



Matthews Health Clinic

Approved

NEW APPLICATION

Denied

Date ____/____/____

Last name First name MI SSN/W-7/Cares ID

NBA ID (Please leave blank) Birth Date: mm/dd/yyyy Age Gender: Male Female Race _____

Street Address PO Box (mailing only)

City State Zip Code

Home Phone Alternate Phone Cell Phone Work Phone

Language Need Interpreter? Yes No

Housing: Own Rent Community Shelter Lived in Mecklenburg or Union Cty. for:
 Staying with Family/Friends Homeless _____ yrs _____ months

Household Name (Please leave blank) Marital Status: Single Married Divorced Widow(er)
 Separated Civil Union Family Size _____

Do you work? Yes No If yes, where? _____
For how long? _____
If no, where did you last work and when? _____

Do you currently have health insurance? Yes No

Have you or anyone listed in this application applied for Medicaid? yes no If yes, who? _____

Have you or anyone listed in this application served in the US Military? yes no If yes, who? _____

Have you been seen by any Carolina's Medical Center Facility within the last two years, including the Behavioral Health Center? Yes No If yes, when, where and why? _____

Emergency Contact Information:

Name: _____ Relation _____ Phone _____
Name: _____ Relation _____ Phone _____

I certify that the above information is correct and grant the staff at Matthews Health Clinic permission to release pertinent financial records.

SIGNATURE _____ Date ____/____/____
Patient/Authorized Representative

List Family Members (Only spouse and children)								
Last Name	First Name	Relationship	DOB mm/dd/yy	Sex F/M	Marital Status	Race	SS# or W-7	Applying for this person?
								Yes No
								Yes No
								Yes No
								Yes No
								Yes No
								Yes No

CREDIT REPORTING AUTHORIZATION

In determining whether you are eligible, Matthews Health Clinic may need to get a consumer report from a credit-reporting agency. Matthews Health Clinic will only use your consumer report to check your social security number, financial information, work status, and address. Your consumer report will not be shared with anyone who is not working with Matthews Health Clinic.

By signing this document, you give your permission for Matthews Health Clinic or a company hired by Matthews Health Clinic to get one copy of your consumer report from a credit reporting agency before you are selected for Matthews Health Clinic and if you are selected for Matthews Health Clinic, another copy six (6) months later.

I certify that to the best of my knowledge, all statements are true and correct.

Applicant's Signature

Spouse's Signature

Date: _____ / _____ / _____

Matthews Health Clinic *(office use only)*

FINANCIAL CALCULATION

Number of household members considered in income calculation _____

1. Total Income (gross) \$ _____ per month

X 12 months \$ _____ Annual

Biweekly /2x2.15 **Weekly** / #weeks x 4.3 **2 Times per month** / 2 x 2

2. Total Unearned Income \$ _____ Per month

X 12 months \$ _____ Annual

TOTAL INCOME (1+2) \$ _____ Yearly

Notes: _____

Processed by _____ Date _____ / _____ / _____

MATTHEWS HEALTH CLINIC

Volunteers In Medicine

Date: _____

Name: _____

Income & Expense Monthly Review

(For self-employed applicant 3 months, otherwise 1 month)

INCOME (Monthly)	Month of	Month of	Month of
Gross Income	\$	\$	\$
Child support (receiving)	\$	\$	\$
Alimony (receiving)	\$	\$	\$
Family/Friends support	\$	\$	\$
Food Stamps, Disability, SSI, Retirement, HUD, Welfare, Etc.	\$	\$	\$
Rental Property	\$	\$	\$
Other (please explain)	\$	\$	\$
Total Monthly Gross Income	\$	\$	\$
Total Annual Gross Income	\$	\$	\$
BANK INFORMATION (Monthly)			
Personal Account	\$	\$	\$
Deposits: Checking/Money Market	\$	\$	\$
Deposits: Savings	\$	\$	\$
Business Account	\$	\$	\$
Deposits: Checking	\$	\$	\$
Total Deposits	\$	\$	\$
Total Annual Gross Income	\$	\$	\$
EXPENSES (Monthly)			
Rent/Mortgage	\$	\$	\$
Water	\$	\$	\$
Gas/Electricity	\$	\$	\$
Telephone (listed in your name)	\$	\$	\$
Cable/Direct TV/Dish	\$	\$	\$
Internet	\$	\$	\$
Food	\$	\$	\$
Vehicle Payment(s) (monthly)	\$	\$	\$
Vehicle Insurance (monthly)	\$	\$	\$
Gasoline	\$	\$	\$
Medical/Dental Expenses	\$	\$	\$
Tuition/College Loans	\$	\$	\$
Child Support (paying)	\$	\$	\$
Alimony (paying)	\$	\$	\$
Child care	\$	\$	\$
Entertainment/Vacation	\$	\$	\$
Property Taxes (monthly)	\$	\$	\$
House Insurance (monthly)	\$	\$	\$
Total Monthly Expenses	\$	\$	\$

*Please attach copy of supporting documents above****Please attach COPY of documentation of the above***



Matthews Health Clinic

Volunteers in Medicine

LETTER OF SUPPORT*

Date: _____

I, _____ (name of person providing support), pay rent and utilities on behalf of
 or for _____ (person being supported). I am not financially responsible for
 his/her bills nor able to buy his/her medications. I provide room and board in the amount of
 \$ _____ per month (dollar value of support).

 Signature

 Printed Name

 Address

 Phone Number

***IF MORE THAN ONE PERSON IS SUPPORTING YOU, YOU WILL NEED TO GET A LETTER OF SUPPORT FROM EACH ONE.**

STATEMENT OF NO INCOME: If you have **no** monthly income please read and sign the following statement.

I, _____ do not currently have any income, which includes but is not limited to, wages, unemployment benefits, disability benefits, self-employment income, Social Security and retirement. I understand that it is my responsibility to report to Matthews Health Clinic the start of any income within 10 days of its beginnings. IF YOU HAVE NO INCOME PLEASE TELL US HOW YOUR HOUSEHOLD BILLS ARE PAID. IF ANOTHER PERSON PAYS THE BILLS, PLEASE PROVIDE A SIGNED LETTER(S) OF SUPPORT.

IT IS VERY IMPORTANT ALL INCOME INFORMATION IS PROVIDED. PROVIDING THIS INFORMATION WILL NOT AUTOMATICALLY DISQUALIFY YOU AS A PATIENT. INCOME GUIDELINES ARE PREDETERMINED BY THIS CLINIC.

By signing this document I am agreeing that all of the information is accurate to the best of my knowledge.

Name _____ Signature _____ Date _____

MATTHEWS HEALTH CLINIC HEALTH HISTORY

NAME: _____ DATE: _____
Print Last First MI

ADDRESS: _____
Street apartment City State zip

PHONE: _____
Home Work Cell

WHY WOULD YOU LIKE TO MAKE AN APPOINTMENT WITH THE DOCTOR? (WHAT IS THE PROBLEM)

<p>List current medications (dose & frequency):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>If there are more, list on a separate attached sheet.</p>	<p>List any medications you are allergic to & the reaction you experienced:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>List all other allergies:</p> <p>_____</p> <p>_____</p> <p>_____</p>								
<p>List all over the counter or herbal medications that you take on a regular basis:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">List all previous hospitalizations and surgeries</th> <th style="text-align: left; border-bottom: 1px solid black;">Date</th> </tr> </thead> <tbody> <tr> <td style="border-bottom: 1px solid black;">_____</td> <td style="border-bottom: 1px solid black;">_____</td> </tr> <tr> <td style="border-bottom: 1px solid black;">_____</td> <td style="border-bottom: 1px solid black;">_____</td> </tr> <tr> <td style="border-bottom: 1px solid black;">_____</td> <td style="border-bottom: 1px solid black;">_____</td> </tr> </tbody> </table>	List all previous hospitalizations and surgeries	Date	_____	_____	_____	_____	_____	_____
List all previous hospitalizations and surgeries	Date								
_____	_____								
_____	_____								
_____	_____								

Social History ** please be honest **

1. Do you smoke? _____ Yes _____ No _____ Previously
 If yes, how many packs per day _____ and for how many years? _____.
2. Do you drink alcohol? _____ Yes _____ No _____ Previously
 If yes, how many drinks per day _____ and how many drinks per week? _____.
3. Do you use street drugs? _____ Yes _____ No _____ Previously
 If yes, what kind? _____ and have you ever shared needles? _____ Yes _____ No

*** Please check all that apply to **YOUR** previous or current health ***

GENERAL:

- Weight change in the last year
 Increase by _____
 Decrease by _____
- Accident, injury or illness not listed above:

- Unusual Childhood Illness:

- Recent travel outside the USA:

CARDIOVASCULAR:

- Heart attack/angina
- Chest pain
- Palpitations/irregularities
- High blood pressure
- Heart murmur
- Rheumatic fever
- Valve problem
- Poor circulation
- Varicose Veins/blood clots
- Thrombophlebitis
- Other:

PULMONARY:

- Unexplained shortness of breath
 At night?
- Pneumonia
- Chronic bronchitis
- Emphysema
- Asthma
 Date of last attack? _____
- Cough
- Blood/blood tinged cough
- Sinus condition
- Hay fever
- Other:

ENDOCRINE:

- Diabetes
- Thyroid condition
- Cortisone treatment
- Obesity
- Other:

RHEUMATOLOGY:

- Stiff or swollen joints
- Back Pain
- Sciatica
- Bursitis
- Arthritis, rheumatism, or gout

INFECTIOUS DISEASE:

- Serious infection
 What: _____

- Tuberculosis (or positive skin test)
- Night sweats
- Fever
- Other:

GASTROINTESTINAL:

- Nausea/vomiting
- Diarrhea
- Constipation
- Recent change in bowels
- Ulcers
 When: _____
- Yellow jaundice
- Hepatitis
- Gall bladder disease
- Pancreatitis
- Heartburn/indigestion
- GI bleeding
- Bloody stool
- Black tarry stools
- Oily/clay colored stools
- Hemorrhoids
- Abdominal pain
- Bloating/gas pains
- Hernia
- Colitis/spastic colon
- Diverticulitis
- Other:

NEUROLOGICAL:

- Headaches:
 Migraine
 Tension
 Sinus
- Seizure disorder
- Neuritis/neuralgia
- Meningitis/polio
- Stroke
 Date? _____
- Dizzy spells/blackouts
- Vertigo
- Weakness/numbness in extremity
- Unconsciousness
- Nervousness
- Vision problem
 Date of last exam: _____
- Hearing problem
- Other:
- MISCELLANEOUS:**
- Depression
- Recent death of family/friend

- Increased pressure from work, spouse, family
- Crying spells
- Insomnia
- Extreme weakness/tiredness
- Nervous breakdown/mental illness
- Changes in skin
- Other:

GENITO-URINARY:

- Kidney damage
- Kidney stone
- Bladder infection(s)
- Blood in urine
- Frequent urination
- More than 1 urination at night
- Albumin, pus, protein in urine
- Venereal disease
- Discharge from penis
- Swollen testicle
- Prostate trouble
- Other:

MENSTRUAL HISTORY:

- Onset of menses: _____
 Date of last period: _____
 Length of period: _____
- Number of pregnancies: _____
- No. of miscarriage/abortions: _____
- Pregnancy complications: _____

- Menstrual irregularity
- Severe cramps
- Mental tension before/during periods
- Decreased flow
- Flooding
- Spotting/discharge
- Other:

HEMATOLOGY/ONCOLOGY:

- Bleeding disorder
- Anemia
- Easy bruising
- Enlarged lymph nodes
- Cancer/tumor
- Other:

PREVIOUS TREATMENT:

- Special Diet
- Blood thinners
- Tranquilizers
- Vitamins
- Frequent laxatives
- Birth control pills
- Treatment for alcoholism
- Treatment for drug use
- Other:

FAMILY'S HEALTH HISTORY

CONDITION	YES	BLOOD RELATIVE/ RELATIONSHIP	CONDITION	YES	BLOOD RELATIVE/ RELATIONSHIP
Anemia			High blood pressure		
Arthritis			Thyroid hyper or hypo		
Asthma			Hepatitis		
Bladder Infection			Headaches or migraines		
Blindness			Heart Attack		
Bronchitis			Heart Failure		
Cataracts			Kidney infections or stones		
Cirrhosis of the liver			Seizures		
Diabetes: Non-insulin			Sexually transmitted diseases		
Diabetes: Insulin dependent			Strokes		
Emphysema			Tuberculosis		
Cancer			Ulcers		

Family History: Please write "yes" in the "yes" column if a blood relative has ever been treated for the listed condition and then provide the nature of the relationship. For example: grandfather, uncle, sister, etc.

Matthews Health Clinic

Phone: 704-841-8882 Fax: 704-841-8879

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient's Name: _____ DOB: _____

Patient's Address: _____
_____**Information to be released FROM** *(to get records from your previous health care provider)*

Facility and/or doctor's name: _____

Address: _____

Phone: _____

Date of services requested: From _____ TO _____

Check information to be released (used or disclosed): Office notes radiology reports/imaging x-rays
 Laboratory/pathology reports EKG/monitors Other (specify) _____Check purpose of disclosure: medical review legal review personal use other (specify) _____**Information to be released TO: MATTHEWS HEALTH CLINIC**

113 North Ames Street, Matthews, NC 28105

Phone: 704-841-8882 Fax: 704-841-8879

Will the health care provider requesting the authorization receive any financial or in-kind compensation in exchange for using or disclosing the health information described above? <input type="checkbox"/> YES <input type="checkbox"/> NO (office use only)
--

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and /or human immunodeficiency virus (HIV). I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the providing organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this private health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Printed Name: _____ Signature: _____ Date: _____
(Patient/Authorization Representative)

*Please note, if information relating to the treatment of drug or alcohol abuse is being released, for a patient under the age of 18, the patient must also sign this **authorization**.*

Minor signature _____