PATIENT INFORMATION

PATIENT NAME: _____

IF UNDER AGE 16 PARENT/GUARDIAN NAME: _____

STREET ADDRESS: _____

MAILING ADDRESS: _____

HOME PHONE: _____ MESSAGE PHONE: _____

IF PATIENT IS HOMELESS PLEASE INDICATE APPROPRIATE SITUATION:

□ LIVE IN SHELTER □ LIVE IN CAR □ LIVE ON STREET □ LIVE WITH RELATIVE □ LIVE WITH FRIEND

□ OTHER: _____

DATE OF BIRTH: _____/_____/_____ AGE: _____ SEX: M F RACE (optional): _____

MARITAL STATUS: □Married □Divorced □Never Married □Widowed □Living together

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

HOUSEHOLD COMPOSITION (Please list ALL persons, including patient who live in the household)

Name	Relationship	Age	Employed Y or N
	PATIENT (SELF)		

Total in household: _____

How many of the household live off the Patient's Income: _____

HOUSEHOLD MONTHLY (or average) INCOME: _____ (This is used only for demographic collection purposes)

MEDICAL HISTORY

LAST DOCTOR YOU SAW: _____

DATE OF LAST DOCTOR VISIT: _____

HAVE YOU BEEN SEEN AT BPICC BEFORE? Y N IF YES WHEN? _____

CURRENT MEDICATIONS:

Medication	Strength	Times/Day	Prescribed By	Last Prescribed

DO YOU SMOKE? Y N HAVE YOU EVER SMOKED? Y N HOW LONG HAVE YOU SMOKED _____

WHEN DID YOU QUIT _____ AMOUNT YOU SMOKE _____

IS THERE A BIOLOGICAL FAMILY HISTORY OR HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

(check all that apply)

□ Cancer □Diabetes □Asthma □Hepatitis □Depression □High Blood Pressure
□Heart Problems □Mental Illness □Alcoholism □High Cholesterol □Anxiety
□Thyroid Problems □Allergies □Seizure Disorder □Other _____

MEDICATION ALLERGIES/SENSITIVITIES:

Medication	Reaction

I UNDERSTAND THAT BPICC WILL NOT BE RESPONSIBLE FOR DIAGNOSTIC TESTING, LABS, HOSPITAL CHARGES, OR REFERRALS TO SPECIALIST UNLESS I RECEIVE A SPECIFIC VOUCHER FOR SUCH SERVICE REFERRALS. I UNDERSTAND THAT I MUST ARRANGE FOR PAYMENT OF THESE CHARGES BEFORE TESTING IS DONE OR BY APPLYING TO MY LOCAL COMMUNITY SERVICE AGENCY.

PLEASE READ COMPLETELY!

CLINIC INFORMATION

Welcome to Bonner Partners in Care Clinic, inc. We want to help you with your health care needs, but there are some kinds of treatment we cannot provide which is explained below. Please ask at the front desk if you have questions because this can save you time here today.

1. We are unable to provide care for: cuts (lacerations), broken bones, pregnancy, vision exams or dental care. We do not provide care that is already available in the community through Panhandle Health District such as; family planning, routine pap smears, testing for sexually transmitted disease, immunizations.
2. **We are not part of any government agency. Doctors, nurses and other staff are all volunteering their time at the clinic.** All staff members are volunteers, including the medical providers who work on a rotating basis. Patients cannot be assured of any certain staff member on any given night.
3. **We are not a part of Panhandle Health District.** They kindly donate this clinic space for our use at no cost. Please do not call them with questions about this clinic or the treatment you receive here.
4. We operate on Tuesday evenings only. We cannot answer medical questions or refill prescriptions during the week or over the phone.
5. **You are a patient of THIS CLINIC (BPICC) and NOT of the individual medical providers who volunteer their time. Do not contact the medical providers at their private office for any questions or refills from services received at this clinic.** You are at any time welcome to call the practice of any medical professional you see at BPICC to become a patient of that practice per their policy and protocols. BPICC will not be responsible for costs incurred for your treatment outside of BPICC.
6. **WE DO NOT PROVIDE ANY CONTROLLED DRUGS** (pain medications, diet pills, narcotics)

Our success of this clinic depends on you, the patient. Please remember that all of the people here are volunteering their time. Without them, we would not be here to assist you. Please be respectful and courteous. Make sure that your visit to the clinic is necessary, because we are only open one (1) evening per week we try to make sure that the care we do provide is needed. If you have any further questions, please ask – we are here to help you.

My signature below is acknowledgement that I have read and understand this information.

Patient (Guardian) signature: _____ Date: _____

Printed Patient Name: _____