GRACE CLINICS OF OHIO

Date: _____

PATIENT INFORMATION

First Name		Last Name	
DOB	Sex ◯ Female ◯ Male	Phone	
Address		County	
City		State	Zip

Marital Status ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Language ◯ English ◯ Spanish ◯ Portuguese ◯ Haitian Creole ◯ Ukrainian ◯ Other

Race ◯ Asian ◯ Pacific Islander ◯ Black ◯ African ◯ Native American ◯ White ◯ European ◯ Multiracial

Ethnicity ◯ Hispanic / Latino ◯ Not Hispanic / Latino

Do you meet Grace Clinic income guidelines? ◯ Yes ◯ No **Do you have insurance?** ◯ No ◯ Medicaid ◯ Other

Do you want to pray with our prayer team during your visit? ◯ Yes ◯ No **Religious Preference?**

GUARDIAN INFORMATION - If patient is under the age of 18, please complete the information below

Parent Guardian Name DOB Relationship ◯ Parent ◯ Guardian

RELEASE OF INFORMATION & CONSENT FOR TREATMENT

I, _____ hereby give Grace Clinic of Ohio permission to release health records and/or give verbal information about my health to any and all healthcare providers from whom I may seek additional care or treatment arising from and reasonably related to the services provided by Grace Clinics of Ohio. I also give any and all healthcare providers from whom I may seek additional care or treatment from and reasonably related to the services provided by Grace Clinics of Ohio, permission to obtain copies of health records and/or to receive verbal information about my health. I understand that the information released and/or obtained will be used only for the purposes of providing care at Grace Clinics of Ohio or for other reasons only after a release has been signed for that particular purpose.

I _____ hereby consent to the provision of care, diagnosis and/or treatment by the Grace Clinics of Ohio and I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing. I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the care, diagnosis and/or treatment and am not subject to duress or under undue influence.

REVIEW OF PATIENT RIGHTS & RESPONSIBILITIES

_____ I have read and I understand the Patient Rights & Responsibilities as posted in Grace Clinics of Ohio. I have had the opportunity to ask questions or request explanation from a volunteer and/or staff member.

_____ I have read and I understand the notice of Limited Liability for Free Clinic Volunteer Health Care Professionals, Board Members, Officers, Employees, and Independent Contractors as posted in Grace Clinic of Ohio. Being mentally competent and under no duress or undue influence, I am giving informed consent to the qualified immunity that extends to health care providers of Grace Clinics of Ohio, Inc. who provide diagnosis, care, or treatment as long as no compensation is received or expected and is provided in a free clinic.

_____ I have read and I understand the Telemedicine Consent Form, and authorize Grace Clinic of Ohio to allow me/the patient to participate in a telemedicine (video conferencing service)

_____ I authorize Grace Clinics of Ohio to use my photos/videos for promotional materials, advertisements, social media, and other communications, without payment. This permission applies to all formats and markets, now and in the future, and continues indefinitely unless I revoke it in writing. I understand these materials will become the property of Grace Clinics of Ohio and will not be returned. I release Grace Clinics of Ohio from all liability related to the use of these materials

Turn Over for Medical History →

GRACE CLINICS OF OHIO

PAST MEDICAL HISTORY

_____ NO TO ALL

_____ ADDP / ADHD
_____ AIDS / HIV
_____ ACID REFLUX
_____ ANEMIA
_____ ANXIETY DISORDER
_____ ASTHMA
_____ AUTISM
_____ AUTO IMMUNE DISEASE
_____ BLADDER OR KIDNEY PROBLEMS
_____ BLOOD DISORDER
_____ CANCER
_____ DEPRESSION
_____ DIABETES
_____ DIVERTICULOSIS
_____ EAR OR HEARING PROBLEMS
_____ ECZEMA
_____ FIBROMYALGIA
_____ GI PROBLEMS
_____ GOUT
_____ HEAD INJURY / CONCUSSION
_____ HEADACHES
_____ HEART PROBLEMS
_____ HEPATITIS
_____ HERNIA
_____ HIGH CHOLESTEROL
_____ HYPERTENSION
_____ HYPERTHYROIDISM
_____ HYPOTHYROIDISM
_____ LIVER DISEASE
_____ LUNG DISEASE
_____ MENTAL ILLNESS
_____ MULTIPLE SCLEROSIS
_____ MUSCLE,JOINT OR BONE PROBLEM
_____ NEUROLOGICAL
_____ PERIPHERAL VASCULAR DISEASE
_____ SEIZURES / EPILEPSY
_____ SLEEP APNEA
_____ STROKE
_____ OTHER
_____ OTHER