



Date: _____

PATIENT INFORMATION

First Name		Last Name	
DOB	Sex <input type="radio"/> Female <input type="radio"/> Male	Phone	
Address		County	
City	State	Zip	
Marital Status <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Other			
Language <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Portuguese <input type="radio"/> Haitian Creole <input type="radio"/> Ukrainian <input type="radio"/> Other			
Race <input type="radio"/> Asian <input type="radio"/> Pacific Islander <input type="radio"/> Black <input type="radio"/> African <input type="radio"/> Native American <input type="radio"/> White <input type="radio"/> European <input type="radio"/> Multiracial			
Ethnicity <input type="radio"/> Hispanic / Latino <input type="radio"/> Not Hispanic / Latino			
Do you meet Grace Clinic income guidelines? <input type="radio"/> Yes <input type="radio"/> No		Do you have insurance? <input type="radio"/> No <input type="radio"/> Medicaid <input type="radio"/> Other	
Do you want to pray with our prayer team during your visit? <input type="radio"/> Yes <input type="radio"/> 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

_____ All care and services provided in-house at Grace Clinics are always free of charge. If your provider orders testing that must be sent to an outside laboratory or facility, you may receive a bill from that organization.



PAST MEDICAL HISTORY

_____ NO TO ALL

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