JEAN B PURVIS COMMUNITY HEALTH CENTER OF BUTLER COUNTY

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APPLICATION

Date: ____________________ ☐Medical ☐Dental ☐Medical & Dental

PATIENT INFORMATION

LAST NAME: ____________________________

FIRST NAME: ____________________________

Middle Initial: ____________________________

Do you have health insurance? ☐Yes ☐No

Do you have dental insurance? ☐Yes ☐No

Are you a Veteran? ☐Yes ☐No

Former Last Name: ____________________________

Sex at Birth: ☐ Female ☐ Male

Date of Birth: _______ /_______ /________

SSN: ________-________-_________

Address: ____________________________

____

Zip Code: ____________________________

City: ____________________________

State: ____________________________

Phone Number: ________-________-_________

Consent to Text: ☐Yes ☐No **(appt. reminders)**

*** Permission to leave a voice mail** ☐Yes ☐No

Email: ____________________________

*** The Community Health Center (CHC) is not insurance.**
All services provided by CHC are free.
CHC is Volunteer-Powered and Community-Funded.

EMERGENCY CONTACT

Name: ____________________________

Relationship: ____________________________

Phone Number: ________-________-________

EMPLOYMENT INFORMATION

Employer Name: ____________________________

Employer Phone: ________-________-__________

Occupation: ____________________________

OPTIONAL INFORMATION

(the following information helps CHC to serve you better and to apply for grants & funding – THANK YOU for helping us to continue our mission!)

Language: ____________________________

Race/Ethnicity: ☐African American ☐Asian ☐Caucasian ☐Latino/Hispanic ☐Middle Eastern ☐Native American ☐Other ____________

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Partner

Gender Identity: ☐Male ☐Female ☐Transgender ☐Gender Non-Conforming ☐Choose not to disclose

Pronouns: ☐He / Him ☐She / Her ☐They / Them

US Citizen: ☐Yes ☐No **US Resident:** ☐Yes ☐No

Education: ☐Some High School ☐GED ☐High School Grad ☐Vocational ☐Some College ☐College Grad

Medicaid Status: ☐Pending (Date applied):______________ ☐Not Eligible-Citizenship ☐Not Eligible-Income ☐Not Eligible-Non-Compliance ☐Aetna ☐Gateway ☐United Healthcare ☐UPMC for You

Transportation: ☐I have transportation ☐I do NOT have transportation

Employment Status: ☐Full Time ☐Part Time ☐Seasonal ☐Self-Employed ☐Retired ☐Disabled ☐Unemployed

How did you hear about us? ☐Butler Hospital ☐CCR ☐Church ☐Current/Former Patient ☐Dept. of Human Services ☐Family/Friends ☐Hospital (Other) ☐Online Search ☐Physician ☐Social Service Agency ☐Specialist ☐ TV/Radio ☐VA ☐Other

LAST NAME: ________________________________

FIRST NAME: ________________________________

DATE OF BIRTH: ________________________________

INCOME INFORMATION

Total # in Household: ________________________

# of Adults: _______ **# of Children (under 18):** _______

$____________ **Total Household Monthly Income**

Did you file a tax return last year? ☐Yes ☐No **Tax return attached?** ☐Yes ☐No

* To request a copy of your tax return, complete IRS form 4506 or call 1-800-908-9946

Below, please identify all members of your household and all sources of household income. CHC defines "household" as the tax filer, spouse and dependents.

Name	Date of Birth	Source of Income *(employment, SSI, child support, unemployment, retirement, etc.)*	Amount *(monthly gross)*	Proof Attached
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

Why do I need to provide my pay stubs and tax returns? *To determine eligibility for services and CHC can provide assistance in acquiring medications at a free or reduced cost. Many drug manufacturers have Prescription Assistance Programs (PAP).* ***ALL of the drug manufacturers who offer PAP require income verification.***

DECLARATION OF NO INCOME

I, ____ (print name), confirm to the fact that I do not and have not received any income in the past three months. This includes wages from employment or self-employment, alimony, cash assistance, child support, pension, social security, unemployment, and/or workers compensation.

I certify that this information provided is complete and accurate to the best of my knowledge. I understand that the services provided by the Community Health Center are based on income guidelines. I understand that upon employment or receipt of any income, I must submit proof of income to the Community Health Center.

Print Name ______________________________Signature________________________________Date_____________

HISTORY AND PHYSICAL

LAST NAME: ______________________________

FIRST NAME: ______________________________

DATE OF BIRTH: ______________________________

Have you been in the hospital or emergency room in the past 12 months? ☐**Yes** ☐**No**

If yes, how many visits have you had in the past 12 months? ________________

Do you live in an unsafe environment or have any fears for your physical safety? ☐**Yes** ☐**No**

Who was your previous primary care physician? ______________________ **Date last seen?** __________

Are you receiving behavioral health (counseling) services? ☐**Yes** ☐**No**

Name of Facility? ____

LIST ALL CURRENT MEDICATIONS:

(including prescriptions, aspirin, vitamins, supplements, herbal remedies and over-the-counter medications)

Please bring all current prescriptions to your initial medical appointment.

____________________________ ____________________________ ____________________________

____________________________ ____________________________ ____________________________

____________________________ ____________________________ ____________________________

PREFERRED PHARMACY: ____

Allergies: ____

Do you have a Latex allergy? ☐Yes ☐No

Immunizations:

Flu Shot:	__________	*(Year)*	Tetanus:	__________	*(Year)*	Hepatitis B:	__________	*(Year)*
Pneumonia:	__________	*(Year)*	TB Test:	__________	*(Year)*	Covid-19:	__________	*(Year)*
Other?:	__________	*(Year)*						

Social History:

	Current	**Former**		
Cigarette Use?	☐Yes ☐No	☐Yes ☐No	How many packs per day?	________________
			How long have you smoked?	________________
Chewing Tobacco/Snuff?	☐Yes ☐No	☐Yes ☐No		
Illicit Drugs?	☐Yes ☐No	☐Yes ☐No		
Alcohol?	☐Yes ☐No	☐Yes ☐No	How many drinks per week?	________________
Caffeine?	☐Yes ☐No	☐Yes ☐No	How many cups per day?	________________
Substance Abuse?	☐Yes ☐No	☐Yes ☐No		
Glasses / Contacts?	☐Yes ☐No		When was your last eye exam?	________________
Dentures?	☐Yes ☐No		When was your last dental exam?	________________
Seatbelts?	☐Yes ☐No			
Regular Exercise?	☐Yes ☐No			
E-Cigarette/Vape Status?	☐ Never ☐Current ☐Former			

Medical History (Current and Past Medical Conditions):

Condition		Condition	
High Blood Pressure	☐Yes ☐No	Stomach Ulcers/Gerd	☐Yes ☐No
Diabetes	☐Yes ☐No	Hepatitis/Liver Disease	☐Yes ☐No
Heart Disease	☐Yes ☐No	Gallstones/Gall Bladder Disease	☐Yes ☐No
Asthma	☐Yes ☐No	Kidney Disease/Kidney Stones	☐Yes ☐No
Stroke	☐Yes ☐No	Back Problems	☐Yes ☐No
Date ____________		Bladder or Kidney Infection	☐Yes ☐No
Cancer	☐Yes ☐No	Prostate Disease	☐Yes ☐No
Type ____________		Gonorrhea/Syphilis/Chlamydia	☐Yes ☐No
Anemia	☐Yes ☐No	Alcohol/Drug Abuse	☐Yes ☐No
Elevated Cholesterol	☐Yes ☐No	Mental Illness	☐Yes ☐No
Seizures	☐Yes ☐No	Blood Transfusion	☐Yes ☐No
Arthritis	☐Yes ☐No	HIV/AIDS	☐Yes ☐No
Type ____________		Tuberculosis	☐Yes ☐No
Thyroid Disease	☐Yes ☐No	Anxiety/Depression	☐Yes ☐No
Allergies (environmental)	☐Yes ☐No	Other:	☐Yes ☐No
Pneumonia/Bronchitis	☐Yes ☐No	Specify ____________________	
Emphysema	☐Yes ☐No	____________________	

Surgical History:

____ *(Date)* ____________

____ *(Date)* ____________

Most Recent:

PAP: __________ *(Year)* Lab Work __________ *(Year)* EKG __________ *(Year)*

Mammogram: __________ *(Year)* Colonoscopy __________ *(Year)*

Family History: *(Relationship: mother, father, brother, sister, paternal/maternal grandmother or grandfather, paternal/maternal aunt or uncle)*

Condition		
Alcohol/Drug Abuse	☐Yes ☐No	Relationship ____________________
Allergies	☐Yes ☐No	Relationship ____________________
Arthritis	☐Yes ☐No	Relationship ____________________
Asthma	☐Yes ☐No	Relationship ____________________
Blood/Bleeding Disorder	☐Yes ☐No	Relationship ____________________
Cancer	☐Yes ☐No	Relationship ____________________
Type ____________		
Glaucoma	☐Yes ☐No	Relationship ____________________
Heart Disease	☐Yes ☐No	Relationship ____________________
Kidney Disease	☐Yes ☐No	Relationship ____________________
Mental Illness/Suicide	☐Yes ☐No	Relationship ____________________
Seizures/Convulsions	☐Yes ☐No	Relationship ____________________
Stomach Ulcers	☐Yes ☐No	Relationship ____________________
Stroke	☐Yes ☐No	Relationship ____________________
Tuberculosis	☐Yes ☐No	Relationship ____________________

DENTAL ASSESSMENT

LAST NAME: ______________________________

FIRST NAME: ______________________________

DATE OF BIRTH: ______________________________

Are you a veteran? ☐Yes ☐No

Do you receive medical care outside of the VA? ☐Yes ☐No **If yes, Physician:** ____________________________

Are you a college student? ☐Yes ☐No **If yes, Name of College or University:** __________________________

Do you have dental insurance? ☐Yes ☐No **Do you have Medicare?** ☐Yes ☐No

Dental History:

Have you had any problems with the following:

☐	Bad Breath	☐	Jaw Pain
☐	Blisters on Lips or Mouth	☐	Loose Teeth
☐	Bleeding, Sensitive Gums	☐	Periodontal (gum) Disease
☐	Broken Fillings or Teeth	☐	Sensitivity to: ☐hot ☐cold ☐sweets ☐biting
☐	Clicking or Popping Jaw		
☐	Food Trapped Between Teeth	☐	Sores/Ulcers in Mouth
☐	Grinding or Clenching Teeth	☐	Swelling/Abscess

Have you avoided dental care in the past because of fear? Please explain: ___________________________________

Are you ambulatory – can you get in and out of the dental chair without assistance? ☐Yes ☐No

Have you been advised by your medical doctor to take a PRE-MEDICATION before dental treatment? ☐Yes ☐No

Reason? ____

Are you pregnant? ☐Yes ☐No If Yes, Due Date: ______________________

Do you take aspirin daily? ☐Yes ☐No **Do you take a blood thinner?** ☐Yes ☐No

Do you wear a ☐Denture ☐Partial ☐Upper ☐Lower ☐No

Do you currently have any teeth hurting? ☐Yes ☐No

If yes, where? ☐Upper R ☐Upper L ☐Lower R ☐Lower L

Do you have a constant bad taste in your mouth? ☐Yes ☐No

Have you ever been diagnosed with gum disease or bone loss? ☐Yes ☐No

Have you had any swelling of the face due to a toothache in the past year? ☐Yes ☐No

Have you taken antibiotics for dental pain and/or infection in the past year? ☐Yes ☐No

Can you move any of your teeth with your fingers? ☐Yes ☐No

Do your gums bleed when you brush or floss? ☐Yes ☐No

Do you brush your teeth daily? ☐Yes ☐No **Floss your teeth daily?** ☐Yes ☐No **Use mouthwash daily?** ☐Yes ☐No

When was your last dental visit? ____________ *(year)*

What procedure(s) were done? ____

When was your last dental cleaning? ____________ *(year)*

Please tell us what dental problems you're having: ____

____