JEAN B PURVIS COMMUNITY HEALTH CENTER OF BUTLER COUNTY

103 Bonnie Drive, Butler, PA 16002 | p: 724.841.0980 | f: 724.841.0984 | info@butlerhealthclinic.org

Application Date: ______________________ ☐**Medical** ☐**Dental** ☐**Behavioral Health** ☐**Vision** ☐**Derm**

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	Response	Condition	Response
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	Response	Relationship
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 ______________________________________