Home & Away Ministries

HEALTH & WELLNESS CLINIC

210 East Park Avenue Luck, WI, 54837 715-472-7770

Patient Information

First Name _____ MI _____ Last Name _____

Address _____ City _____

State _____ Zip _____ County _____

Gender (circle): Male Female Age: _____ Date of Birth: _____/_____/_____

Marital Status (circle): Single Married Separated Divorced Widowed

E-mail address: _____

Phone Number: Home (____)_____ Work (____)_____

Cell (____)_____

Can we leave a message (circle)? Yes No Best way to reach you _____

Race (check): ___White (non-Hispanic origin) ___White (Hispanic origin)

___American Indian/Alaskan Native ___Black (non-Hispanic origin)

___Other ___Asian/Pacific Islander (non Hmong)

Emergency Contact: Name _____ Phone Number (____)_____

Please list the names and contact numbers of physicians, hospitals, clinics that have treated you in the past 2 years:

Name	**Phone Number**	**Reason**	**Date**

Name: _____ Date of Birth: _____

Please list current prescribed medications:

Medication	Dosage	Frequency

Please list over the counter or herbal medication that you take on a regular basis:

Medication	Dosage	Frequency

Please list any medications you are allergic to and the reaction you experienced:

Medication	Allergic Reaction experienced	Date

Please explain your medical/dental needs: _____

_____

_____

I certify that the above information is correct.

Name:_____ Relation _____ Date: _____

Name:_____ Relation _____ Date: _____

Name: _____ Date of Birth: _____

This information is **optional** and will help us determine if you qualify for other services (e.g. low or no cost prescriptions) and *will not affect your ability to receive assistance from the Home and Away Health & Wellness Clinic*. We would appreciate you providing the following information. Thank you!

If you are currently employed please list your employer: _____

Financial Information:

Number of people living in your home: ____ Number of children under age 18 in your home ____

Indicate below all of your sources of income for the last full month:

Monthly Wages (*hourly wage (x) number of hours/week (x) 4*) _____

Veteran's Benefit _____ SSI Benefit _____ Child Support _____

Public Assistance/W-2 _____ Worker's Comp _____ Self Employment _____

Social Security _____ Unemployment _____ Other _____

Assets (bank/saving account, life insurance/stocks, etc.) _____

Total Monthly Income _____ Size of your family _____

Do you have access to insurance (including MA,GAMC, BadgerCare) (circle)? Yes No

Please list insurance and reason for not accessing: _____

_____

How did you hear about this Clinic? _____

Have you or anyone listed in this application served in the US Military? Yes No

What would you do if this Clinic wasn't here?_____

Do you have any concerns for yourself or a family member regarding any of these areas? Our staff may be able to assist in making a referral for you or connect you with an appropriate resource.

- ❑ Abuse or Neglect
- ❑ Parenting or Family Relationships
- ❑ Depression
- ❑ Dental Health
- ❑ Drugs or Alcohol abuse
- ❑ Finding Employment
- ❑ Financial Advice
- ❑ Food
- ❑ Help in your Home
- ❑ Housing Needs
- ❑ Mental Health
- ❑ Transportation
- ❑ Tobacco Use
- ❑ Other

Name: _____ Date of Birth: _____

Today's Date: _____ Time: _____

Date	Temp	BP	Pulse	O2 Stat	Other
Height	Weight				

Nurse's Notes:

Doctor's Notes: