Health Partners Free Clinic

PATIENT DEMOGRAPHIC/CONSENT FOR TREATMENT

First Name	Middle Initial	Last Name	Prefix	Suffix
Address		Address 2		
City	State	Zip	County	
Home Phone	Other or Mobile Phone Numbers			

Race	Sex	Marital Status	Birth Date	SSN	# Children at home

# in Family	Veteran (Y/N)	Insurance (Y/N)	Language

May we text you? If so, please list a cell number.	Email
Employed (FT, PT, Temp)	Employer
Education Level	Today's Date

HOUSEHOLD MONTHLY INCOME

Including: Salary/Wages, SS Retirement and Disability, SSI, Retirement/Pension, Unemployment, and Workman's Comp

Total Patient Monthly Income: _____

HOUSEHOLD MEMBERS

Household Member	Birth Date	Race	Relationship	Monthly Income
				$
				$
				$
				$
				$

IN AN EMERGENCY WE MAY CONTACT

Name _____ Relationship _____

Address _____ Phone # (s) _____

_____

CONSENT FOR TREATMENT

I hereby acknowledge and understand that by signing this voluntary care Patient Consent Form, I am giving informed consent to the provisions of diagnosis, care and/or treatment by Health Partners Free Clinic, Inc. and cannot bring a tort or other similar action including an action on a medical or other health-related claim, against Health Partners Free Clinic unless the action or omission of Health Partners Free Clinic constitutes willful or wanton misconduct.

_____ _____

Signature of patient or representative/guardian Date

_____ _____

Print patient name or representative/guardian Date

_____ _____

Witness Date