**The Marie Blanchard Friendship Clinic**

**General Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name: (First, Last)** | | **DOB:** | **Date:** | | |
| **Address:** | | **City:** | **State:** | | **Zip Code:** |
| **Contact Phone # ( ) Email:** | | | | | |
| **Marital Status:** Married Single Widowed Divorced  Separated Other | | | | Significant Other Name: | |
| **Maiden/Other Names:** (1) | | (2) | (3) | | |
| **Emergency Contact 1:** | Relation: Phone # ( | | | ) | |
| **Emergency Contact 2:** | Relation: Phone # ( | | | ) | |
| **Other Providers:**  **Name:**  **Name:**  **Name:**  **Name:**  **Name:** | Specialty:  Specialty:  Specialty:  Specialty:  Specialty: | | | Still Seeing? Yes No  Still Seeing? Yes No  Still Seeing? Yes No  Still Seeing? Yes No  Still Seeing? Yes No | |
| **IF PATIENT IS UNDER 18 YEARS OF AGE:**  Father’s Name:  Mother’s Name:  Address (if different from above)  Contact Phone # | | | | | |
| **How did you learn about The Marie Blanchard Friendship Clinic?**  Family/Friend Idaho 211 Hospital Clinic Sign Other agency (please specify) \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­\_\_\_\_\_\_\_\_\_\_  Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Preferred Pharmacy Name: Location: Phone #** | | | | | |

**PLEASE TURN OVER AND COMPLETE BACK PAGE**

**HOUSEHOLD FINANCIAL INFORMATION**

**Are you employed:** Yes \_\_\_\_\_\_ No: \_\_\_\_\_\_\_\_\_

Occupation & Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hourly wage: \_\_\_\_\_\_\_\_\_\_\_ Monthly Pay: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you receiving unemployment payments**: Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

How much? \_\_\_\_\_\_\_\_\_\_\_\_\_ For how long? \_\_\_\_\_\_\_\_\_\_\_\_

**Household Size:** Adults: \_\_\_\_\_\_\_\_\_\_ Children under 18 years of age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Does Patient Have** | **YES** | **NO** |
| * Medical Insurance |  |  |
| * Medicaid/SHIP |  |  |
| * Medicare Part B |  |  |
| * Veteran’s Benefits/Assistance |  |  |
| * Other (please specify): | | |
| Name of Insurance Company (if applicable): | | |

|  |  |
| --- | --- |
| **Income** | |
| **Does Patient Receive:** | Monthly Amount |
| * Alimony | $ |
| * Child Support | $ |
| * Disability | $ |
| * Pension | $ |
| * Social Security | $ |
| * WIC | $ |
| * Food Stamps | $ |
| * Supplemental Housing | $ |
| * Transportation Assistance | $ |
| * Employment Wages | $ |
| **Total Income per Month** |  |
| **Total Income per Year** |  |

|  |  |
| --- | --- |
| **Expenses** | |
| **Monthly Financial Necessities** | Monthly Amount |
| * Food | $ |
| * Rent/Mortgage | $ |
| * Telephone | $ |
| * Utilities | $ |
| * Car/Transportation | $ |
| * Car Insurance | $ |
| * Child Care | $ |
| * Child Support Payments | $ |
| * Alimony Payments | $ |
| * Credit Cards | $ |
| * Other \_\_\_\_\_\_\_\_\_\_\_\_ | $ |
| **Total Expenses per Month** |  |
| **Total Expenses per Year** |  |