**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 NoStill Seeing? Yes NoStill Seeing? Yes NoStill Seeing? Yes NoStill 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** |  |