Physicians' Care Clinic

A Volunteer Effort of the DeKalb Medical Society

Patient Recertification Form (PLEASE PRINT)

Section 1: **Do you have type of insurance that covers your health?** Yes____ No_____

If yes, Name of Insurance Plan:_____ **Policy #:** _____ **Date issued:**_____

Last Name:_____ **First Name:**_____ **Middle Int:**_____

Street Address:_____ **Apt#** _____ **City/State:**_____ **Zip:**_____

Home Telephone/Contact #:_____ **Cell #:**_____ **Work #:**_____.

Social Security Number:_____. **Date of Birth:**_____ **Male** _____ **Female** _____

E-mail address:_____ **Single**___ **Married**___ **Divorced**___ **Widowed**___

Nationality: _____ **Race**_____ **Primary Language** _____.

Do you communicate in English? Yes___ **No**___ **If no, you must have an interpreter accompany you.**

Emergency Contact: **Phone#:**

Section 2:

Family Size: Adults_____ **Under 18**_____ **18-21 Student**_____ **Unborn**_____ **Family Size Total**_____

Family Member Name	Date of Birth	Employer	Gross Earned Income Last 4 wks	Gross Unearned Income Last 4 wks
Self:			$	$
Spouse:			$	$
Child:			$	$
Child:			$	$
Child:			$	$
Disability Income			$	$
Social Security Income			$	$
Unemployment Income				
(add earned and unearned income to determine total)		**Total Income** $_____		

Section 3:

- I understand that falsification of any information contained on this form will result in my inability to receive health care at the Physicians' Care Clinic.
- I acknowledge that failure to provide the Physicians' Care Clinic with an update on changes in my financial status may result in my inability to receive health care.
- I further acknowledge that I understand the Physicians' Care Clinic is staffed by volunteer physicians and staff. I accept treatment based on this knowledge.

Required Documents:

- __X___ Valid Picture ID attached to application (drivers' license, visa, passport, green card, state issued ID card)
- __X___ Proof of residency attached to application (rental lease, utility bill showing current address, notarized letter from landlord)
- __X___ Proof of income attached to application (1 month of check stubs ; statement from employer on company letterhead **Wage inquiry statement from the Georgia Department of Labor, if unemployed)**

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Signature of Patient Date

(**Valid for one year**) Expiration date:_____

Clinic Location: Vinson Health Center 440 Winn Way Decatur, GA 30030
Administrative Office: 2675 North Decatur Rd. Suite 406 Decatur, GA 30033 Phone: 404-501-7940 Fax: 404-501-7199