Physicians' Care Clinic

A Volunteer Effort of the DeKalb Medical Society

Thank you for your interest in the Physicians' Care Clinic. PCC is **NOT** an Insurance Agency. -- PCC is an advocate for affordable healthcare for our patients.

To qualify for the clinic you must be an **uninsured DeKalb County adult resident** with a Limited income and not Medicare/Medicaid eligible**.**

The PCC is a volunteer led **evening clinic** held from 6 -8pm at 440 Winn Way in Decatur. **Patients are seen by appointment only** on Tuesdays and Wednesdays.

All of our physicians are volunteering their time to see patients after their office hours. *At no time may patients contact any volunteer care provider at their private office.*

Patients who are untruthful, uncooperative, intoxicated, abusive or behave inappropriately To our staff, volunteers, or other patients will become ineligible for clinic services.

We see patients for non-emergent Primary Care. We *do not* provide emergency care, trauma care, dental care, STD tests, pregnancy tests, pre-natal care, family planning or do workman's compensation, employment or disability physicals.

Upon receipt of the ***completed application and required documents*** we will review for eligibility, if approved, contact you for your first appointment.

Mail to: Physicians' Care Clinic
2675 N. Decatur Road, Ste. 406
Decatur, GA 30033

Fax to: **404-501-7199**

$20.00 donation is requested at each clinic visit.

Patients need to see the doctor every six months to ensure that your medication is working. If you have not seen the doctor within six months and need a medication refilled, you will receive a 30 day supply until you are seen by a medical provider.

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

Physicians' Care Clinic, Inc. Patient Application Form (PLEASE PRINT)

Section 1: Do you have any 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 Phone :_____Work Phone: _____

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

e-mail address:_____ Single___ Married__ Divorced___ Widowed___

Nationality:_____Ethnicity_____Primary Language_____
Do you communicate in English? **Yes__ No___** If no, do you have an interpreter who will accompany you? **Yes__ No___**

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:			**$**	**$**
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)**

- __X____ **How long have you lived in DeKalb County** : _____

/

Patient Signature **Date**

(Valid for one year) Expiration date:_____

How did you hear about the Physicians' Care Clinic?_____

Reason for your first visit:_____

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PHYSICIANS' CARE CLINIC, Inc.

MEDICAL HISTORY FORM

Print Name:_____ / _____ / _____

(Last) (First) (Middle) M or F Date of Birth

ALLERGIES	REACTION	ALLERGIES	REACTION

Have you had a cough for more than three weeks? **Yes**__ **No**__ If yes, have you been tested for TB? **Yes**___ **_No**____

Have you had a TB skin test? **Yes**___ **No**___ If yes, were the results **Positive**_____ **Negative**_____

If positive, have you been treated for TB? **Yes**___ **No**____ If yes, date and treatment received?:_____

Do you smoke? **Yes**__ **No**__ If yes, how many packs per day?_____ How many years have you smoked?_____

Do you drink alcohol? **Yes**___ **No**___ If yes, how much _____How many years?_____

Do you drink caffeine? **Yes**__ **No**___ Do you have any unexplained weight gain / loss? **Yes**___ **No**___ which?_____

Do you have any history of drug or alcohol addiction? **Yes**____ **No**_____ If yes, what type _____ Last treated _____

Current Medications	Dose	Current Medications	Dose	Current Medications	Dose

Please check yes or no if you have, or have had a history of any of the following:

	Yes	No
Childhood Illnesses:		
Measles	___	___
Mumps	___	___
Rubella	___	___
Rheumatic fever	___	___
Vision		
Glaucoma	___	___
Cataracts	___	___
Glasses/contacts	___	___
Ear/Hearing Disorders		
Impaired	___	___
Hearing Aid	___	___
Sinus Problems		
Allergies	___	___
Hay fever	___	___
Infections	___	___
Lung Problems		
Oxygen dependent	___	___
Asthma	___	___
Emphysema	___	___
Bronchitis	___	___
Pneumonia	___	___
Tuberculosis	___	___
Heart/Vascular Problems		
Hypertension	___	___
Heart Murmur	___	___
Heart Attack	___	___
High Cholesterol	___	___
Stroke	___	___
Blood Clots	___	___
Muscle/Bone/Joint		
Arthritis	___	___
Gout	___	___
Mobility issues: _____		
Assistive devices used:_____		
Breast Problems	___	___
Last mammogram	_____	
Female Problems	___	___
Last pap smear	_____	
Contraception used	_____	

	Yes	No	
Infectious Disease:			
HIV/AIDS	___	___	
Syphilis	___	___	
Other STD	___	___	
Gastrointestinal Disorders			
Ulcers	___	___	
Liver disease	___	___	
Hepatitis	___	___	Type:_____
Pancreatitis	___	___	
Gall Bladder	___	___	
Diverticulitis	___	___	
Hemorrhoids	___	___	
Other:	___	___	(explain:_____)
Kidney/Urinary Disorders			
Bladder Infections	___	___	
Kidney Stones	___	___	
Prostate	___	___	
Nervous System Disorders			
Seizures/Epilepsy	___	___	
Headaches	___	___	
Migraines	___	___	
Endocrine Disorders			
Thyroid disease	___	___	
Diabetes	___	___	
Insulin	___	___	
Pituitary disease	___	___	
Blood Disorders			
Anemia	___	___	
Other	___	___	explain:_____
Blood Transfusion	___	___	
Skin Disorders			
Rash/Hives	___	___	
Eczema	___	___	
Other: (explain)_____			
Cancer/Tumors	___	___	if yes, explain below
_____			
_____			
Emotional Issues	___	___	if yes, explain below
_____			
_____			

List any major surgeries with dates(continue on next page if needed):_____

Health history, continued: **Name:**_____ **DOB:**_____

PATIENT SIGNATURE:_____ **DATE:**_____