Community Health Services of Union County, Inc.

Free Clinic Screening Form

I WAS REFERRED HERE BY _____

Name: _____ Date of Birth _____

Mailing Address: _____ Zip Code: _____

Email address _____

Phone: (H)_____ (C)_____ Gender: ☐ Male ☐ Female

Employer Name: _____ Retired ___ Unemployed ___ Disabled ___ Number in household: _____

Race: ☐Asian ☐ Black/Afr. Amer. ☐ Hispanic/Latino ☐ Multi-Racial ☐ Native American ☐ White ☐Other

Income: ☐ $0 to $9,999 ☐ $25,000 to $34,999 ☐ $75,000 to $99,999 ☐ $150,000 to $199,999

☐ $10,000 to $14,999 ☐ $35,000 to $49,999 ☐ $100,000 to 149,999 ☐ $200,000 or more

☐ $15,000 to $24,999 ☐ $50,000 to $74,999

Health Insurance Coverage (please check all that apply) ☐ Medicare ☐ Medicare Supplement

☐ Medicaid ☐ Private Insurance ☐ NC Health Choice ☐ None

Have you been hospitalized in the last 90 days?

Yes_____ No_____ Date of Hospitalization_____

The last time I saw a Doctor was _____. I certify that I am not now under the care of a Primary Health Care Provider.

Signature_____Date_____

AUTHORIZATION FOR COMMUNITY HEALTH SERVICES TO RELEASE INFORMATION

TO WHOM IT MAY CONCERN:

This is to authorize Community Health Services, its affiliates, agents, and employees to release any and all records, documents, information, or opinions which may be requested regarding my medical and/or financial condition to any person, firm, agency, or organization as to which such information appears to Community Health Services to be reasonable or necessary to enable myself and/or my family to obtain medical, financial, and/or rehabilitative assistance.

Signature_____ Date_____

June 2020