

# PATIENT HISTORY FORM

(Patients must reapply every year)

**FOR CLINIC STAFF USE ONLY**

AGENCY #	CHART #	WWC #
ENROLLMENT/RE-ENROLLMENT DATE	<input type="checkbox"/> I HAVE VERIFIED THIS PATIENT'S LAWFUL PRESENCE DOCUMENTATION IS CURRENT.	

**PATIENT INSTRUCTIONS: Please fill in each part below. Shaded areas need to be filled in completely.**

IDENTIFICATION

LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME
LAST 4 NUMBERS OF YOUR SOCIAL SECURITY NUMBER		DATE OF BIRTH	AGE

WHAT ETHNICITY ARE YOU? CHOOSE ONE BELOW.

I am Latina and/or Hispanic.       I am not sure if I am Latina or Hispanic.       I am not Latina or Hispanic.

WHAT RACE(S) ARE YOU? CHECK ALL THAT ARE TRUE.

<input type="checkbox"/> Black/African American	<input type="checkbox"/> Asian	<input type="checkbox"/> Pacific Islander
<input type="checkbox"/> White	<input type="checkbox"/> Alaska Native	<input type="checkbox"/> I am not sure
<input type="checkbox"/> American Indian	<input type="checkbox"/> Aleutian Islander	<input type="checkbox"/> Other:
<input type="checkbox"/> Latina/Hispanic	<input type="checkbox"/> Native Hawaiian	

ENROLLMENT

<p>DO YOU HAVE PRIVATE INSURANCE OR MEDICAID?</p> <p><input type="checkbox"/> Yes, I have Medicaid.</p> <p><input type="checkbox"/> Yes, I have private insurance. Check below if any are true.</p> <p style="padding-left: 20px;"><input type="checkbox"/> but I have a high deductible.</p> <p style="padding-left: 20px;"><input type="checkbox"/> but it does not cover cancer screening.</p> <p><input type="checkbox"/> No, I do not have private insurance.</p> <p><input type="checkbox"/> No, I do not have Medicaid.</p>	<p>DO YOU HAVE MEDICARE?</p> <p><input type="checkbox"/> Yes, part A only.</p> <p><input type="checkbox"/> Yes, parts A and B.</p> <p><input type="checkbox"/> No, I do not have Medicare.</p>	<p>WOULD YOU LIKE US TO SEND YOU A LETTER REMINDING YOU OF YOUR SCREENING? (test phase only)</p> <p><input type="checkbox"/> Yes</p> <p style="padding-left: 20px;"><input type="checkbox"/> In English</p> <p style="padding-left: 20px;"><input type="checkbox"/> In Spanish</p> <p><input type="checkbox"/> No, I do not want a letter reminding me of my screening.</p>
--	--	---

To the best of my knowledge, the GROSS MONTHLY (before taxes) income for my household is:	Number of people living on this income including myself (this may include people not living in your house):
---	---

CONTACT

HOW DID YOU HEAR ABOUT THE WOMEN'S WELLNESS CONNECTION FREE BREAST AND CERVICAL CANCER SCREENING EXAMS?

<input type="checkbox"/> Brochure / Poster	<input type="checkbox"/> Hotline (866-951-9355)	<input type="checkbox"/> TV Ad
<input type="checkbox"/> Clinic Staff / Physician	<input type="checkbox"/> Newspaper Ad	<input type="checkbox"/> Women's Wellness Connection event or staff person
<input type="checkbox"/> Friend / Family Member	<input type="checkbox"/> Patient Navigator	<input type="checkbox"/> Other:
<input type="checkbox"/> Health Fair	<input type="checkbox"/> Radio Ad	

PLEASE PROVIDE THE FOLLOWING NUMBERS WE CAN REACH YOU AT:	Mailing Address		
Home Phone number	City	State	Zip
Work Phone number	County		
Cell Phone number	Email Address		
Emergency Contact List a phone number for someone who could call you if your phone number changes in the future or in an emergency:			