St. Matthew's Medical Clinic Initial Registration

Please print

Name: DOB: Gender: Male Female

If patient is a minor Parent/legal guardian name:

Mailing address:

Phone number(s): cell other

Email: print clearly
Do you check your email daily? Yes No
May we contact you via email regarding appointments? Yes No

Emergency Contact: Name
Address:
Phone:

Primary Language:
Reason for attending St. Matthew's Medical Clinic:

Previous Doctor:
Reason for leaving previous doctor:

Where/how did you hear about St. Matthew's Medical Clinic?

I have received a copy of the St. Matthew's Welcome Information and I agree to follow the clinic rules in order to remain a patient: Yes No

Patient signature: Date:

All care at St. Matthew's is free, although donations are accepted.
The following information will help us apply for grants to better serve our patients.

Do you have medical insurance? Yes No Medicaid Medicare
If you do not have medical insurance:
When was the last time you had medical insurance?
Why was your insurance cancelled?
Have you ever applied for Medicaid? Yes No
Have you ever applied for CICP? Yes No

Are you employed? Yes No
If so, where are you employed?
What is your position?