MEDICAL CLINIC AT ST. ANN CATHOLIC CHURCH

ST. JOSEPH PRIMARY CARE
a ministry of caring

DAY OF GRACE – a free Sunday Clinic, operated by St. Joseph Primary Care & Volunteers

4400 FALLS OF NEUSE RD., SUITE 101, RALEIGH, NC 27609 4057 US 70 BUS W., CLAYTON, NC 27520
O: (919) 386-6866 F: (919) 386-6867 WWW.STJPC.COM

Formulario de registro de pacientes
Patient Registration Form

Información del paciente

Información del paciente (Patient Information)		
Apellido: Last Name	Nombre: First Name M.I.:	Nombre anterior: Previous Name
Dirección Postal: Apartamento: Mailing Address/Apt#		Ciudad/estado/código postal: City/State/Zip
Teléfono de casa: Home Phone	Teléfono celular: Cell Phone	Teléfono del trabajo: Work Phone
Método preferido para recibir llamadas de cortesía y otras mensajes electrónicos: ☐Voz ☐Texto ☐Email Preferred Method of Contact for reminder calls (Please select only one option) ☐Voice ☐Text ☐Email		
Si voz, favor de indicar el numero preferido: ☐Casa ☐Celular ☐Trabajo Please select preferred number: ☐ Home ☐ Cell ☐ Work		Email:
Fecha de nacimiento: Date of Birth	Sexo: ☐Masculino ☐Feminino	Médico familiar o pediatra: Family Physician or Pediatrician
Estado civil: ☐Prefiere no contester ☐*Casado* ☐*Soltero* ☐*Divorciado* ☐*Viudo* Marital Status: ☐ Decline ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed		
Nombre del empleador: Employer Name		Contacto de emergencia: Emergency Contact Name
Teléfono del contacto de emergencia: Emergency Contact Nombre		Relación con el paciente: Relationship to Patient

Información adicional

Información adicional (Additional Information)	
Are you a parishioner at St. Ann Catholic Church?	Which mass do you attend?
Race: ☐ Prefiere no contester/Decline ☐ American Indian ☐ Asian ☐ Hispano/Hispanic ☐ Blanco/White ☐ Black or African American ☐ Other / *Otro*	Etnia (marque una)/Ethnicity: ☐ Prefiere no contester/Decline ☐ Hispanic/Latino ☐ Non-Hispanic
Do you have medical insurance, Medicare or Medicaid? *¿Tiene usted seguro medico, Medicare o Medicaid?*	

Reason for visit / *Razón de su visita*

☐Diabetes / Hypertension *Diabetes /Hipertensión* ☐Primary Care/ *Medicina Primaria*

☐Gynecology /PAP *Ginecología / PAP* ☐Other / *Otro*

Do you have an immediate medical need? / *¿Necesita atención médica inmediata?* ☐ Yes/ Si ☐No/No

Why? / *¿Porque?*

Are you… / *Esta usted…*

☐Employed / *Empleado* ☐Disabled / *Disabilitado* ☐Unemployed / *Sin empleo* ☐Retired / *Jubilado*

☐Student / *Estudiante* ☐Other / *Otro*

Name and address of employer *Nombre y dirección de empleador*

RELEASE, WAIVER OF LIABILITY, AND ARBITRATION AGREEMENT

I understand, acknowledge* of Written Explanation of Arbitration, *and agree to the following and

I hereby verify that the information I have given on this application is true and correct

I understand that Day of Grace is a free Sunday Clinic, operated by St. Joseph Primary Care, a 501(c)(3) not-for-profit organization, and volunteers and that under North Carolina law, a volunteer medical or health care provider shall not be liable for damages for injuries or death alleged to have occurred by reason of an act or omission in the medical or health care provider's voluntary provision of health care services unless it is established that the injuries or death were caused by gross negligence, wanton conduct, or intentional wrongdoing on the part of the volunteer medical or health care provider. I also understand that in order for me to continue to receive care, I need to get a health card. I understand there is an ONE-TIME fee to obtain the card. I confirmed that I am an active parishioner at St. Ann Catholic Church. I DO NOT seek drugs (pain medications).

Firma del paciente o representante legal del paciente____________________ Fecha:____________
Signature

PATIENT NAME:________________________________DOB:_________________________DATE:_____________

CHIEF COMPLAINT: WHAT IS THE REASON FOR THE VISIT?
FOR EXAMPLE: ABDOMINAL PAIN
CUAL ES LA RAZON DE LA VISITA POR EJEMPLO: DOLOR ABDOMINAL

HOW LONG DO YOU HAVE THE PROBLEM?
POR CUANTO TIEMPO HAS TENIDO ESTE PROBLEMA?

WHAT MAKE IT WORSE?
QUE HACE SE EMPEORE?

WHAT MAKE IT BETTER? HAVE YOU TRY TO TAKE ANY MEDICATIONS
QUE HACE SENTIRSE BIEN O MEJOR? /HAZ TRATADO ALGUNA MEDICINA PARA ESTA CONDICION?

HAVE YOU SEEN ANY DOCTOR FOR IT? WHAT THE NAME OF THE DOCTOR /CLINIC?
HAZ VISTO ALGUN DOCTOR POR ESTO? CUAL ES EL NOMBRE DEL DOCTOR O LA CLINICA?

HISTORY OF PRESENT ILLNESS

PAST MEDICAL HISTORY:

SMOKE:____ALCOHOL USE__________________________

ALLERGIES:____MEDICATIONS:__________________________

FOR WOMAN:
Date last period began: ___________________________ Date prior period began: ________________________

BP:	**Height:**	**Weight:**	**BMI:**	**RN:**

NURSE:____DATE:__________________________

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PATIENT NAME:_________________________________DOB:__________________________DATE:_____________

EXAM	NORMAL	ABNORMAL FINDING
HEENT:		
NECK:		
CHEST:		
HEART:		
ABDOMEN:		
NEURO:		
MUSCULOSKELETAL JOINTS:		
EXTREMITIES:		

ASSESSMENT:

PLAN

RECOMMENDED FOR A FOLLOW UP ☐ Yes ☐ No

PHYSICIAN/HEALTHCARE PROVIDER