



Lorain County Free Clinic Patient Application

Patient Information:

Full Name: _____

SSN: _____ - _____ - _____

Marital Status: Single / Married / Divorced / Widowed

Address: _____ APT # _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Sex: Male / Female / Other Race/Ethnicity: _____

Primary Language: _____

Previous Doctor: _____ Have you ever been seen at the Free Clinic before? Yes / No

Contact Information:

Phone Number: Mobile: _____ Home: _____ Email: _____

Emergency Contact: Name: _____ Relationship: _____ Phone Number: _____

Number of Members in Household: _____

Please List everyone living in your household:

LAST NAME	FIRST NAME	DOB	RELATIONSHIP

Income/Employment:

Employment Status: Are you currently employed? Yes / No Employer: _____

Wage: _____ Hours: _____ Student / Part Time / Full Time / Temporary / Contract / Self

Total Monthly Household Income: _____

Are you retired: Yes / No

Is your spouse employed: Yes / No / NA Spouses monthly income: _____

I NEED TO COME TO THE CLINIC FOR: _____

I UNDERSTAND THAT THE ABOVE INFORMATION WILL BE VERIFIED. I UNDERSTAND ADDITIONAL INFORMATION MAY BE REQUESTED.

PLEASE SIGN AND DATE HERE: _____