Adult	Screen	ing	For	m
Date				

Screener

Third City Community Clinic 1107 N. Broadwell Grand Island, NE 68803

	Name	r			(#) (#) V/#)	*1 869 To		
	L	ast	First		Middle Initial	•		1 1
9	Address		City		Zip	14 til		
	County	SS#		Age_	Sex	<u> </u>		
	Date of Birth	ar ea	Telephon				W 1945	
		•8	Message	Phone				
Race	: Hispanic	Marital St	atus Educa	ation Level:			* .	
	White	Married_	9 or <	:	Proo	f of Income		
	Asian	Single	10-11		Taxe			
e 2	Black	Divorced_	12		Medi	caid denial letter_		
	Am I	Separated_						٠.
. 0.5	Other	Widowed_	UNK	·	Language	Spoken		¥
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чнымая								333
		HOUSE	EHOLD FINAN	CIAL INF	ORMATION	·		* * .
2.4	Medicaid-				nsurance	-Y or N	K. 1 W	
. .	Assistance		(ADC, SSI,		nent, Disability,			
	WIC, Social Se	ecurity, Alimony)						
		e an application				N		•
-		, <u>**</u> .,						
(3)	Do you rent or	own a home? M	lonthly paymen	t '				
20		I resources?						
ere 4	Total number		·Numb	er of Child	ren under 18			
	75 .4	me of Employer		ed W:	ages/HR Hrs/\	WK TOTAL		
œs,	Other:							
	Other:							
	Ç 111 U							ŝ
	Monthly	Household Incon	ne before taxes			•		
		pplicant previous		om TCCC?		.1		
		r.	•					*
				нанияная				HRH
0.			MEDICAL IN		ON			
	Do you have a phys	iolon 2				- 10 m	49	*
	What physical prob	lom brings you t	TCCC today?	.1 01	14			
***	Have you seen a phot	reinian about this	nroblem?				#	
	Have you seen a ph	ysician about tins	broniem:					60
	If yes, the name of t Emergency Contact	пе Билгияп						
	Emergency Contact		77:	D-1-4:	hip	Telephone		
	Ta +b 1 1 1	Last	FILST	Relations	uib	Telebrone	:9	
	Is there somebody l	esides your self t	hat you author	ize to receiv	e test results or	medical informati	lon?	
							•8	
	Name		Re	elationship	•	Telephone		12
				in the second se		control type worker		
	a \$5.00 donation is r							d. I
ī	understand that the	above informatio	n may be verifi	ed and that	the information	is complete and a	iccurate.	
					£		×	
	Signature of	patient				•	20	

Date

I understand that the above information will be verified and is complete and accurate to the best of my knowledge.

I also understand that I will be required to follow the following guidelines for continued services at Third City Community Clinic and that failure to comply with these could result in termination from the clinic. This list is not inclusive:

- 1. I will not come to Third City Clinic under the influence of drugs and/or alcohol.
- 2. I will be not rude, disruptive or belligerent at clinic sites, referral offices or by telephone.
- 3. I will not miss clinic appointments without providing notice.
- 4. I will not experience a change in my work or financial situation without notifying clinic staff.
- 5. I will provide accurate and truthful information regarding health status, financial information and work history.
- 6. I will not abuse prescriptions provided by Third City Clinic. I understand these are for my use only and that selling or losing prescriptions cannot be tolerated.

Printed Name			Signature of Patient or Guardian			
Screener		:	Date			