



# Gifford Medical Center

## Patient history

(Please complete for each member of household)

Name: \_\_\_\_\_ Today's date: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Date of birth: \_\_\_\_\_

If minor, name of parent/guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Name of doctor/health care provider: \_\_\_\_\_

**Marital status (check one):**

Married  Civil union  Divorced  Separated  Living with partner  Single

**Employment:**  Full-time  Part-time  Student/child  Retired  Unemployed

Date last employed: \_\_\_\_\_

**Race:**  White  Black  Asian  Hispanic  Other

**Residency (check one):**  Vermont  Out-of-state  Temporary

Name of health insurance company: \_\_\_\_\_

Prescription co-pay amount: \_\_\_\_\_ Can you afford medications:  Yes  No

Did you delay treatment because you could not afford it?  Yes  No

Gross monthly income: \_\_\_\_\_ Number of dependants: \_\_\_\_\_

**Where did you receive medical care?**

Doctor's office  Emergency room  WICC/urgent care  Chiropractor

**When did you last receive medical care?**

0-6 months  6 months-1 year  1-2 years  2-5 years  > 5 years

**If not here, where would you have gone for care?**

Emergency room  Doctor's office  WICC/urgent care  Would not seek care

**Have you applied for:**  Medicaid/VHAP  Dr. Dynasaur  Other public assistance

**Reason for call/visit:**  Access health care  Assist with payment  Assist with meds

**Education:**  8<sup>th</sup> grade or less  Some high school  Some college  Associate degree

Bachelor's  Master's  Doctorate

**Smoking history:**  Smoker  Interested in quitting  Non-smoker

Gifford Affordable Care Program

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