Men's Health and Wellness Clinic
Application

Thank you for your interest in the Men's Health and Wellness Clinic, operated by the Physicians' Care Clinic, Inc., and the DeKalb County Board of Health.

The clinic provides non-emergency primary care. This includes:

- Wellness exams
- Health screenings
- Chronic disease management
- Lab tests
- Follow-up and referrals

The clinic does not provide:

- Emergency care
- Trauma care
- Dental services
- STD testing
- Workers' compensation, employment or disability physicals

Patients are seen on Tuesdays and Wednesdays from 6:00 p.m. to 8:00 p.m. by appointment only. The clinic is in the Board of Health's T. O. Vinson Health Center at 440 Winn Way in Decatur.

To be eligible for services, patients must meet all these criteria:

- DeKalb County resident
- Male
- Age 18 or older
- Limited income
- Uninsured (no health insurance)
- Not eligible for Medicaid, Medicare or veterans' benefits

To prove eligibility, you must complete this application and submit it with the required documents. See pages 4 and 5. You can submit your application and documents by:

- Fax to: (404) 294-3842
- Scan and email to: dekalb.ocdp@dph.ga.gov
- Drop off at: DeKalb County Board of Health, 445 Winn Way, Suite 354, Decatur, Ga. 30030
- Mail to: DeKalb County Board of Health, P.O. Box 987, Decatur, Ga. 30031

If you are approved, you will be contacted to schedule your first appointment. Your clinic visits will be free. Your medical costs will be covered by the Board of Health and other funders.

If you have any questions or need help with completing this application, call (404) 508-7847.

Clinic location: T. O. Vinson Health Center 440 Winn Way, Decatur, Ga. 30030

Physicians' Care Clinic, Inc. Patient Application Form (PLEASE PRINT) (MC)

Section 1: Do you have any type of insurance that covers your health? **YES** _____ **NO** _____
If yes, Name of Insurance Plan: _____Policy #:_____Date issued:_____

Last Name: _____**First Name:** _____**Middle Initial:** _____

Street Address: _____**Apt #** _____**City/State** _____**Zip** _____

Home Telephone/Contact #: _____ Cell Phone: _____Work Phone: _____

Social Security Number:_____ Date of Birth: _____ **Male** _____ **Female** _____
(month/date/year)

E-mail address: _____ Single _____ Married _____ Divorced_____ Widowed _____

Nationality:_____Ethnicity: _____Primary Language: _____
Do you communicate in English? **Yes**_____**No**_____ If no, do you have an interpreter who will accompany you? **Yes** _____ **No** _____

Emergency Contact: Phone #

Section 2:

Family Size: Adults _____ **Under 18** _____ **18-21 Student** _____ **Unborn** _____ **Family Size Total** _____

Family Member Name	Date of Birth	Employer	Gross Earned Income Last 4 wks	Gross Unearned Income Last 4 wks
Self:			$	$
Spouse:			$	$
Child:			$	$
Child:			$	$
Child:			$	$
Child:			$	$
Disability Income			$	$
Social Security Income			$	$
Unemployment Income			$	$
(add earned and unearned income to determine total)		**Total Income**	$ _____	

Section 3

- I understand that falsification of any information contained on this form will result in my inability to receive health care at the Physicians' Care Clinic.
- I acknowledge that failure to provide the Physicians' Care Clinic with an update on changes in my financial status may result in my inability to receive health care.
- I further acknowledge that I understand the Physicians' Care Clinic is staffed by volunteer physicians and staff. I accept treatment based on this knowledge.

REQUIRED DOCUMENTS:

- __X__ **Valid Picture ID** attached to application (drivers' license, visa, passport, green card, state issued ID card)
- __X__ **Proof of residency** attached to application (rental lease, utility bill showing current address, notarized letter from landlord)
- __X__ **Proof of income** attached to application (1 month of check stubs ; statement from employer on company letterhead; **wage inquiry statement from the Georgia Department of Labor, if unemployed)**

- __X____ **How long have you lived in DeKalb County** : _____

_____ /_____
Patient Signature **Date**

(Valid for one year) Expiration date:_____

How did you hear about the Physicians' Care Clinic? _____

Reason for your first visit: _____

Clinic Location: Vinson Health Center 440 Winn Way Decatur, GA 30030
Administrative Office: 2675 North Decatur Rd. Suite 406 Decatur, GA 30033 Phone: 404-501-7940 Fax: 404-501-7199

PHYSICIANS' CARE CLINIC, Inc.

MEDICAL HISTORY FORM

Print Name:_____ / _____ / _____

(Last) (First) (Middle) M or F Date of Birth

ALLERGIES	REACTION	ALLERGIES	REACTION

Have you had a cough for more than three weeks? **Yes**____ **No**____ If yes, have you been tested for TB? **Yes**____ **No**____

Have you had a TB skin test? **Yes**____ **No**____ If yes, were the results **Positive**____ **Negative**____

If positive, have you been treated for TB? **Yes**____ **No**____ If yes, date and treatment received?:_____

Do you smoke? **Yes**____ **No**____ If yes, how many packs per day?____ How many years have you smoked?_____

Do you drink alcohol? **Yes**____ **No**____ If yes, how much _____ How many years?_____

Do you drink caffeine? **Yes**____ **No**____ Do you have any unexplained weight gain/loss? **Yes**____ **No**____ Which?_____

Do you have any history of drug or alcohol addiction? **Yes**____ **No**____ If yes, what type _____ Last treated_____

Current Medications	Dose	Current Medications	Dose	Current Medications	Dose

Please check yes or no if you have, or have had a history of any of the following:

	Yes	No
Childhood Illnesses:		
Measles		
Mumps		
Rubella		
Rheumatic fever		
Vision		
Glaucoma		
Cataracts		
Glasses/contacts		
Ear/Hearing Disorders		
Impaired		
Hearing Aid		
Sinus Problems		
Allergies		
Hay fever		
Infections		
Lung Problems		
Oxygen dependent		
Asthma		
Emphysema		
Bronchitis		
Pneumonia		
Tuberculosis		
Heart/Vascular Problems		
Hypertension		
Heart Murmur		
Heart Attack		
High Cholesterol		
Stroke		
Blood Clots		
Muscle/Bone/Joint		
Arthritis		
Gout		

	Yes	No	
Infectious Disease:			
HIV/AIDS			
Syphilis			
Other STD			
Gastrointestinal Disorders			
Ulcers			
Liver disease			
Hepatitis			Type:_____
Pancreatitis			
Gall Bladder			
Diverticulitis			
Hemorrhoids			
Other:			Explain:_____
Kidney/Urinary Disorders			
Bladder Infections			
Kidney Stones			
Prostate			
Nervous System Disorders			
Seizures/Epilepsy			
Headaches			
Migraines			
Endocrine Disorders			
Thyroid disease			
Diabetes			
Insulin			
Pituitary disease			
Blood Disorders			
Anemia			
Other			Explain:_____
Blood Transfusion			
Skin Disorders			
Rash/Hives			
Eczema			

Mobility issues: _____

Assistive devices used:_____

Breast Problems ____ ____

Last mammogram _____

Female Problems ____ ____

Last pap smear _____

Contraception used _____

Other (explain) _____

Cancer/Tumors ____ ____ if yes, explain below

_____

_____

Emotional Issues ____ ____ if yes, explain below

_____

_____

List any major surgeries with dates(continue on next page if needed):_____

Health history, continued: **Name:** _____ **DOB:** _____

PATIENT SIGNATURE: _____ **DATE:** _____

Please submit a copy of the following REQUIRED documents with this application!

☐ One valid picture identification (ID)

Examples:

- Driver's license
- Visa
- Passport
- Green card
- State-issued ID card

☐ One proof of residency

Official or business mail that shows your name and address.

Examples:

- Rental lease
- Utility/cable bill
- Bank statement
- Notarized letter from landlord or roommate

☐ Proof of income

- *If you are employed:*

  Proof of four (4) weeks of your income.

  Examples:

  - If you are paid weekly, four (4) paycheck stubs.
  - If you are paid twice a month, two (2) paycheck stubs.
  - A statement from your employer on company letterhead that states the amount you make and how often you are paid.
  - If self-employed, a bank statement showing deposits into your account (all other transactions can be marked out to protect your privacy).

- *If you are unemployed:*

  - A wage inquiry statement from the Georgia Department of Labor to prove that you are unemployed. This is free and can be obtained from WorkSource DeKalb at 774 Jordan Lane, Bldg. 4, Decatur, Ga. 30033 or call (404) 679-5200.

- *If you are married:*

  You must also include proof of your spouse's income.

  - Documentation of four (4) weeks of your spouse's pay (as detailed above).
  - If your spouse is unemployed, they must provide a wage inquiry statement (see above).