For Office Use Only QUALIFYING REQUALIFYING	
Today's Date:	Provider name:
Appointment Date and Time:	Last appointment:
Reason for visit:	

Patient Registration Form

Last Name (Legal)	First Name (Legal)	MI:	Former Name/Nickname

Address	City	State	Zip

Home Phone#	Work#	Mobile#
SSN# or TIN#	**Birth Date**	**Driver's License #**

Birth Sex: (Please circle one)	Marital Status
☐ Male ☐ Female ☐ Unspecified	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Primary Race	Non-Primary	Ethnicity
☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ White ☐ Declined	☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ White ☐ Declined	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other ☐ Unknown

Preferred Language	Need Interpretation Services	Employer Name	Status
	☐ Yes ☐ No		☐ Full-Time ☐ Part-Time

Emergency Contact: Name	Relationship	Phone Number(s)

Insurance Plan Name - Skip if uninsured	Gender Identity
Insurance Plan Name ______________________________ ID# ____________________________	☐ Male ☐ Transgender Male/Female to Male ☐ Female ☐ Transgender Female/Male to Female ☐ Other ☐ Chose not to disclose

Housing Status

- ☐ **Doubling Up:** Individuals who are living with others. The arrangement is generally considered to be temporary and unstable, though a patient may live in a succession of such arrangements over a protracted period of time.
- ☐ **Homeless Shelter**: Individuals who are living in an organized shelter for homeless persons at the time of their visit. Shelters generally provide for meals as well as a place to sleep, are seen as temporary and often have a limit on the number of days or the hours of the day that a resident may stay at the shelter.
- ☐ **Institution**: Individuals who spent the prior night incarcerated, in an institutional treatment program (mental health, substance abuse, etc.) or in a hospital
- ☐ **Migrant**: Individual *whose principal employment is in agriculture on a seasonal basis* (as opposed to year-round employment) and who establishes a temporary home for the purposes of such employment.
- ☐ **Not Permanent Housing**: Individuals who do not own or rent their primary housing
- ☐ **Other**: Individuals residing in SRO (single room occupancy hotels) or motels or other day-today paid for housing should also be classified as "other,"
- ☐ **Permanently housed**: Individual owns or rents their primary permanent residence
- ☐ **Seasonal**: Individuals whose principal employment is in agriculture on a seasonal basis (as opposed to year-round employment) and who do not establish a temporary home for purposes of employment.
- ☐ **Street**: This category includes individuals who are living outdoors, in a car, in an encampment, in makeshift housing/shelter or in other places generally not deemed safe or fit for human occupancy.
- ☐ **Transitional**: There is a time limit on how long you can stay in the housing or receive assistance

Date of Last visit with Physician	Physician Name:	Physician Phone:

Have you been to the ER in past year?	If Yes, When?	Hospital?	Reason for Visit
☐ Yes ☐ No			

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CERTIFICATION OF ELIGIBILITY

NO PATIENT WILL BE SEEN AT EITHER CLINIC WITHOUT WRITTEN PROOF OF INCOME

NAME ____
Last First MI

1. What is the **gross** monthly income of your household? _______________
2. How many persons are supported by this income? ____________
3. If you have any of the following health coverage, please check:
   Medicare ________ Medicaid ________ HealthWave/Medical Card ________
   Veteran's Benefits ________ Other ________ I have no health insurance ________

Family Size	Category A	Category B	Category C	Category D
1	$0 – $ 6,440 M. $0 – $ 536	$ 6,440– $12,880 M. $ 536 – $ 1,073	$12,881 – $19,320 M. $ 1,073– $ 1,610	$19,320 – $22,540 M. $ 1,610 – $ 1,878
2	$0 – $ 8,710 M. $0 – $ 725	$ 8,711 – $17,420 M. $ 725 – $ 1,328	$17,421 – $26,130 M. $ 1,328 – $ 1,991	$26,130 – $30,485 M. $ 1,991 – $ 2,540
3	$0 – $10,980 M. $0 – $ 915	$10,980 – $21,960 M. $ 915 – $ 1,830	$20,091 – $32,940 M. $ 1,830 – $ 2,178	$32,940 – $38,430 M. $ 2,178 – $ 3,203
4	$0 – $13,250 M. $0 – $ 1,104	$13,250 – $26,500 M. $ 1,104 – $ 2,021	$24,251 – $39,750 M. $ 2,021 – $ 3,313	$39,750 – $46,375 M. $ 3,313 – $ 3,865
5	$0 – $15,520 M. $0 – $ 1,293	$15,520 – $31,040 M. $ 1,293 – $ 2,368	$28,411 – $46,560 M. $ 2,368 – $ 3,880	$46,560 – $54,320 M. $ 3,880 – $ 4,527
6	$0 – $17,790 M. $0 – $ 1,483	$17,790 – 35,580 M. $ 1,483 – $ 2,714	$32,571 – $53,370 M. $ 2,714 – $ 4,448	$53,370 – $62,265 M. $ 4,448 – $ 5,189
7	$0 – $20,060 M. $0 – $ 1,671	$20,060 – $40,120 M. $ 1,671 – $ 3,061	$36,731 – $60,180 M. $ 3,061 – $ 5,015	$60,180 – $70,210 M. $ 5,015 – $ 5,851
8	$0 – $22,330 M. $0 – $ 1,944	$22,330 – $44,660 M. $ 1,944 – $ 3,408	$40,891 – $66,990 M. $ 3,408 – $ 5,583	$66,990 – $78,155 M. $ 5,583 – $ 6,513
Add for each additional family member	+$2,080	+$4,160	+$6,240	+$7,280

This information is correct and I provide it in order to receive care under the Charitable Health Care Provider Program. (K.S.A. 75-6120). **I understand that if Caritas Clinics, Inc. finds that I have intentionally given false financial information, I will immediately forfeit my right to services.**

______________________ ____
Date Signature of Applicant or Parent or Guardian of Applicant

When/If you file taxes can you mark yourself as Head of Household? ☐ Yes ☐ No

If not, who is:_________________________________

List ALL sources of GROSS MONTHLY INCOME (Before Taxes) for your household:

	Amount
a. Employment (include tips)…………………	____________
b. Unemployment Compensation…………….	____________
c. Worker's Compensation…………………..	____________
d. Food Stamps………………………………	____________
e. Alimony…………………………………..	____________
f. Child support……………………………..	____________
g. Pension……………………………………	____________
h. Social Security……………………………	____________
i. SRS Income (Cash Assistance)……………	____________
j. Housing from friends, family or shelter…..	____________
k. Utilities from friends, family or shelter…..	____________
l. Support from friends, family, etc…………	____________
m. Other ______________________	____________

TOTAL GROSS MONTHLY INCOME

$____________________

Include the income of all adult family members. A family is defined as a group of two or more people who reside together and who are related by birth, marriage or adoption. Family income includes that of the parents and/or step-parents, unmarried or domestic partners, or caretaker relatives living under the same roof.

PATIENT HISTORY FORM

Name: ____DOB:____________________ Date:_________________

PERSONAL MEDICAL/SURGICAL HISTORY:

Condition	Yes	Comments
Acid Reflux (Heartburn/GERD)		
Alcohol or Drug Abuse (circle)		
Allergy (Hay Fever/Seasonal)		
Anemia		
Anxiety		
Arthritis		
Asthma		
Blood Clot		
Cancer (Specify Type)		
Cataracts (both eyes or Rt/Lf)		
Depression		
Diabetes		
Diverticulosis/Diverticulitis		
Emphysema/COPD		
Gallbladder Disease		
Glaucoma		
Gynecological Problems		
Heart Attack		
Hepatitis		
High Blood Pressure		
High Cholesterol		
Kidney Disease/ Failure		
Kidney Stones		
Liver Disease		
Migraine or Other Headaches		
Osteoporosis		
Prostate (enlargement)		
Seizure/Epilepsy		
Skin Condition (eczema/psoriasis)		
Sleep apnea		

Condition	Yes	Comments
Stomach Ulcer		
Stroke		
Thyroid (hypothyroid/hyperthyroid)		
Urinary Problems (specify)		
Other (list)		
Other (list)		

Surgical Procedure (specify)	Yes	Year
Appendectomy (appendix removal)		
Breast Surgery		
Cardiac Pacemaker or Defibrillator		
Cataract		
Caesarean Section		
Colonoscopy		
Coronary Artery Bypass Graft (# arteries)		
Coronary Artery Stent		
Hernia Repair		
Hysterectomy (Total or Partial) circle one		
Knee Surgery (history of)		
LEEP (Cervix Surgery)		
Ovary Ligation (Tubal)		
Removal of Gallbladder		
Spinal Surgery (lumbar, cervical, thoracic)		
Tonsillectomy		
Upper GI Endoscopy		
Vasectomy		
Other (list)		

ALLERGIES: Any allergies or "bad reaction" to medications or other substances? ____ No ____ Yes

If yes, please specify drug(s) and type of reaction: ____

____

MEDICATIONS (Please list prescription medications you are taking currently)

Medication Name	Reason	Dosage	Last Taken
Ex: Lisinopril	high blood pressure	10mg/1 day	today
________________________	____________________	________	__________
________________________	____________________	________	__________
________________________	____________________	________	__________
________________________	____________________	________	__________
________________________	____________________	________	__________
________________________	____________________	________	__________

PATIENT HISTORY FORM

Name: ____DOB:____________________ Date:_________________

Over-the-counter medications and vitamins/mineral/herbal supplements

Name and Brand	**Reason**	**Dosage**
EX:St. John's Wort (Nature's Way)	Feeling down	300 mg/day
__________________	__________________	__________________
__________________	__________________	__________________

FAMILY MEDICAL HISTORY

Indicate which relative has had the following diseases (parents and siblings are most important)

Adopted- _____ Yes _____ No (If yes and you do not know your family history skip the following section).

FAMILY HISTORY **Disease**	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	**Other relative**	**Comments**
No significant history known										
Alcoholism or drug abuse (specify in comments)										
Asthma										
Autoimmune Disease										
Blood disorder (specify in comments)										
Cancer (specify type in comments)										
Coronary Artery Disease (e.g. heart attack,angina)										
Depression or Anxiety (specify in comments)										
Diabetes										
Emphysema (COPD)										
Genetic Disorder (explain)										
Heart Disease (specify in comments)										
High Blood Pressure										
High Cholesterol										
Thyroid Disease										
Kidney Disease										
Kidney Stones										
Psychiatric Illness										
Other (list)										
Deceased*										

*Causes of death: ____

MEN ONLY - Do you have: ____ Prostate Problems _____ Testicular Cancer____ Vasectomy _____ Sexual Dysfunction

WOMEN ONLY

1.) **Reproductive History**

Age at 1st menstrual period _________y.o. First day of last menstrual period__________________

Usual Flow: _____ Heavy _____ Moderate _____ Light Length of period ____________days

Do you have (please circle):

Painful Periods Missed Periods Spotting Between Periods Painful Intercourse

Vaginal Bleeding Unusual Discharge/Infection Recurring Vaginal Infections

PATIENT HISTORY FORM

Name: ____DOB:____________________ Date:_________________

If you have gone through menopause, have you had any postmenopausal bleeding? ____________

Date of last Pap ______________ History of abnormal Paps? ________________________________

Total # of Pregnancies_______ # of Live Births_______ # of Abortions _______ # of Miscarriages _________

2.) Contraceptive History (Please circle the method of contraception you are currently using)

Birth Control Pills Diaphragm/Cap Depo shot Natural Family Planning Norplant

Tubal Ligation Suppository Partner with Vasectomy Hysterectomy Implanon

Condom and/or Foam None IUD Type _______________________ Date Last Placed ___________

Immunizations/vaccinations: Please list date of last given:

Flu:_______________________ Tetanus:_____________________ Pneumonia:_________________

Any major traumatic injuries (motor vehicle accident, fall, etc.)? ____Yes ____ No

If yes, when and what were the injuries?____

SOCIAL HISTORY: (Specify amount per day or week if currently using, or write Never or Quit and date last used)

Tobacco

E-Cigarettes ___________________________

Cigarettes ___________________________

Cigars/Pipe ___________________________

Chewing __________________________________

Recreational Drugs (MJ, Cocaine, Heroine, Amph, etc.)

Type___________________________________

Alcohol

Specify type & amount: ___________________________

Has alcohol use interfered with work or home life? ___Y __ N

Do you ever drink more than intended? _ Y _ N

Has anyone been hurt or at risk by your drinking? ___ Y ___ N

Ready to change? ____ Y ____ N

Concerns about alcohol use in household: ___y____N

With whom do you live? (include roommates, friends, partner, spouse, children, parents, relatives, pets)

Name	Age	Relationship	Name	Age	Relationship
___________________	____	__________	___________________	____	__________
___________________	____	__________	___________________	____	__________

Any major stressors in your life?____

How do you relax/relieve stress? Any interests/hobbies? ____

Occupation (Current) ______________________________________(Past)______________________________

EXERCISE/SLEEP (circle activities/exercise that you do regularly)

Walking Jogging/Running weightlifting Yoga _Bike riding _Swimming Aerobics Dancing

Energy level:__High___Medium__Low_____How is your sleep?____

NUTRITION

How many meals do you usually eat per day? _____ Do you skip meals?_____How often do you eat out? __________

Who prepares the meals at home?______________ Are you on a special diet?_________Food allergies?____________

Vegetarian?______

What and how much do you drink on a typical day? (i.e.: water, caffeine drinks, soda (regular or diet))

Water_______________Coffee_______________Tea_______________Reg Soda_______________Diet Soda_________

Milk_______________Juice_______________Energy Drinks_____________ Alcohol (wine, beer)______________

Your biggest challenge to eating a healthy diet?____

PATIENT HISTORY FORM

Name: ____DOB:____________________ Date:_________________

What is your reason to see a doctor?____

How soon do you need to see the doctor?____

Have you ever been to the emergency room?_____________ If yes which hospital, when and why?

____

____

How long has it been since you have seen a doctor? If more than a year, why?__________________________________

Why are you changing doctors?____

How did you hear about the clinic? Circle one: Social media friend walk-in relative doctor
Hospital: list name____________________ Social Service Agency Other:_______________________

By signing below, I hereby certify that to the best of my knowledge, all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature____Date________________

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Information:

Full Name: ____Date of Birth:________________________________
Maiden or Other Names Used:__________________________________Social Security Number:____________________
Address::____
City:_____________________________________State:____________________________Zip:_____________________
Day Phone #:____Cell Phone #:___________________________________

Release From:

Care Site Name:____
Address:____
City:____State:___________________Zip:___________________________
Phone #:____Fax #:_______________________________________

Release To: St Vincent Clinic; 818 N 7th St; Leavenworth KS 66048 PHONE: 913-651-8860 / FAX: 913-682-4409

Date(s) of Information to be Released:
Dates of Service From:____________To:_____________

Purpose:
☐ Continuation of Care

Information to be Released/Accessed: I would like copies of the items checked below for the treatment dates listed above.
☐ Hospital Discharge Summary ☐ Emergency Discharge Summary ☐ Hospital Outpatients/Clinics Notes for the Past Two Years

Patient Access Information:

- I will provide a picture ID prior to accessing my medical record.
- I may review my medical record without charge. If I request copies of my medical record, I may be charged a fee.
- I will refer my questions regarding treatment prognosis or other clinic matters to my physician.
- A Clinic professional will supervise the review of my medical record.

I Understand That:

- The information to be released may include a diagnosis or reference to the following conditions(s): behavioral health services/psychiatric care, sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.
- Without my express revocation, this authorization will automatically expire 180 days from the date signed below, unless I request an expiration date less than 180 days.
- I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply it.
- Information disclosed pursuant to the authorization may be subject to the **redisclosure** by the recipient and is no longer protected by the HIPAA Privacy rule.

My signature is required to validate this authorization. If I do not sign this authorization, this Care Site will still provide treatment.

____
Signature of Patient/Authorized Person **Authorized Person(s) Relationship (Parent, Guardian, Power of Attorney)** **Date**

____
Authorized Person's PRINTED Name, Address and Phone Number

If patient is unable to sign, document reason:____

____
Signature of Witness **Printed Name of Witness** **Date**

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Ambulatory/Clinic
Permission to Share Information with Persons Involved In My Health Care

We need your written permission to share your information with persons involved in your health care, even appointment information.
Complete this form to instruct us how to communicate information about you and the care you are receiving at this clinic.

NO CONTACT

[ ] Do NOT share any of my personal information with anyone over the phone.
[ ] Do NOT leave messages. I will call this clinic.

MESSAGES

Leave messages with the following checked information on my answering machine/voice mail at the number I provided to this clinic.

[ ] Appointment Information [ ] Treatment/Diagnosis Information
[ ] Medical Instructions [ ] Test Results (Lab, X-Ray, Pathology)

PERSONS INVOLVED IN MY HEALTH CARE

A. The person listed below is involved in the care I am receiving at this clinic.

____________________ ____________________
Name Relationship

Please share the following with the person listed above.

[ ] Appointment Information [ ] Treatment/Diagnosis Information
[ ] Medical Instructions [ ] Test Results (Lab, X-Ray, Pathology

This person may:

[ ] Pick up prescriptions or paperwork [} Schedule or change my appointments

ADDITIONAL PERSONS INVOLVED IN MY HEALTH CARE

B. The person listed below is involved in the care I am receiving at this clinic.

____________________ ____________________
Name Relationship

Please share the following with the person listed above:

[ ] Appointment Information [ ] Treatment/Diagnosis Information
[ ] Medical Instructions [ ] Test Results (Lab, X-Ray, Pathology

This person may:

[ ] Pick up prescriptions or paperwork [} Schedule or change my appointments

SIGNATURE

This authorization to release information to the parties listed above is good for one year from the date below unless you tell us otherwise.

____________________ __________ __________
Signature of Patient/Legal Representative DOB Date

Form **4506-T** (March 2021) Department of the Treasury Internal Revenue Service

Request for Transcript of Tax Return

▶ Do not sign this form unless all applicable lines have been completed.

▶ Request may be rejected if the form is incomplete or illegible.

▶ For more information about Form 4506-T, visit *www.irs.gov/form4506t*.

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 Customer file number (if applicable) (see instructions)

Note: Effective July 2019, the IRS will mail tax transcript requests only to your address of record. See **What's New** under **Future Developments** on Page 2 for additional information.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ ____________

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2016, filed in 2017, will likely not be available from the IRS until 2018. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☐

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately. | / / | / / | / / | / / |

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) Date

▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's signature** Date