PO Box 632
908 W. Washington Street
West Bend, WI 53090
T:262-334-8339

Albrecht Free Clinic

Office Use Only Medical New _____ Update _____
Dental New _____ Update _____

Albrecht Free Clinic Application Form

PATIENT INFORMATION

Today's date: _____

_____ **Date of Birth:** ____/____/____ **Sex** M F Gender Neutral
Applicant - Full Legal Name

If patient is a minor child (younger than 18), please list the name of the accompanying parent(s) or guardian(s), and their relationship(s) to the patient.

Parent/Guardian Name(s): _____
Full legal name

Best phone number I can be reached at (circle one): Home Cell Other Please list all available numbers below

_____ _____ _____
Cell # **Home #** **Other**

Street Address_____**City**_____**State**_____**Zip**_____

Email Address _____ **If none, please check box**☐

Marital status: M W S Sep. D **Veteran?** [ ] Yes [ ] No

RACE: [ ]Asian [ ]Black [ ]Latino/a [ ]Native American [ ] White [ ] Other_____

Primary language:_____ **Interpreter needed:** [ ] Yes [ ] No

If yes, please tell us the interpreter's name and the best telephone # to reach them:

_____ _____
Full legal name **Telephone number**

Living Arrangement (Please select one)

[ ] Own [ ] Rent [ ] Free room & board [ ] Living w/family and/or friends [ ] Transitional facility

[ ] Rehabilitation center [ ] Homeless [ ]Other*(Explain)*_____

What is the highest grade you completed in school? (Please select one)

[ ] Elementary [ ] Some high school [ ] High school diploma or GED [ ] Some college or technical school

[ ] College or technical school degree [ ] Master's Degree [ ] PHd

How did you hear about us? (Please select all that apply)

[ ] Family [ ] Friend [ ] Employer [ ] Website/On-line [ ] Newspaper [ ] Human/Social Services [ ] Physician/Hospital

[ ] TV/Radio [ ] Word of mouth [ ] Other

Please Provide all income information below.

Married - Living with my spouse/significant other
(Check all that apply for you and your spouse)

Unemployed _____ Employed _____

Employer Name: _____

Full Time _____ Part Time _____

My source of income:
_____ Self-Employment
_____ Unemployment
_____ Social Security
_____ Pension
_____ Cash
_____ Other

My Spouse/significant other's source of income are:
_____ None
_____ Employed
_____ Self Employed
_____ Social Security
_____ Unemployment
_____ Pension
_____ Cash
_____ Other

Employer Name: _____

Number of dependents (if any) supported by your income other than yourself: Adults ____ Children_____

Single - NOT living with a spouse/significant other
(Check all that apply for you)

Unemployed _____ Employed _____

Employer Name: _____

Full Time _____ Part Time _____

My source of income:
_____ Self-Employment
_____ Unemployment
_____ Social Security
_____ Pension
_____ Cash
_____ Other

Number of dependents (if any) supported by your income other than yourself: Adults ____ Children_____

HEALTH INSURANCE

Do you currently have any health insurance? Y N
If Yes, circle – Badger Care * Employer Sponsored * Health Care Act * Medicare – Circle all that apply Part A Part B Part D
Do you currently have Dental insurance? Y N
If Yes, circle – Badger Care * Employer Sponsored * Health Care Act * Medicare – Circle all that apply Part A Part B Part D

WHERE HAVE YOU RECEIVED MEDICAL CARE?

Do you have a primary care physician? Y N
If yes, physician name _____ Last Seen _____
How often do you visit the emergency room? _____
Why did you visit the emergency room? _____

SIGNATURE

I certify that all the information on this application is correct to the best of my knowledge. I have not purposefully misled the AFC (Albrecht Free Clinic) to believe my needs to be more serious than they truly are. I authorize the AFC to obtain any information held by Washington County Human Services for the sole purpose of determining eligibility for services.

I understand that if I or any member of my household intentionally misrepresents or withholds facts for the purpose of obtaining medical care from the AFC, that I may be expected to pay for the services provided or no longer be able to receive medical care from the AFC in the future.

_____ _____
Signature **Today's Date**

_____ **Circle One or both: Medical / Dental Patient**
Print Name