Free Clinic – Patient Registration Form

First Name	**Middle** Name	**Last** Name
Address		
City	**State**	**Zip**
Home Phone	**Cell** Phone	**Work** Phone
Email Address	**SSN**	**Driver's License State & Number**
Date of Birth (mm/dd/yyyy)	**Sex** ☐Male ☐Female	**Marital Status** ☐S ☐M ☐D ☐W

Next of Kin

Name	Relationship	Phone

Emergency Contact (if different from above)

Name	Relationship	Phone

I hereby acknowledge and understand that by signing this voluntary patient registration form, I am giving informed consent to the provisions of diagnosis, care and/or treatment by the staff and providers of this free clinic and cannot bring a tort or other similar action including an action on a medical or other health-related claim, against any of the staff or providers of this free clinic unless the action or omission of the free clinic constitutes willful or wanton misconduct.

I also acknowledge that I meet the eligibility criteria for this free clinic, namely that I do not have access to health insurance in the United States.

Signature	**Date**

Please turn in this form with your driver's license to the receptionist.