Outpatient Clinic Application Questionnaire

Date_____

Name	Date of Birth	Age	Occupation	Marital Status	Ethnic Origin ☐ Caucasian ☐ Hispanic ☐ Asian ☐ Black ☐ American Indian ☐ Indian ☐ European ☐ Other
Home Address Street _____ Apartment number _____ City, State, Zip Code _____	Home Phone Cell Phone	Occupation, Employer and Work Address Employer _____ Work Address _____ Work Phone _____			

Have you been seen in this clinic before? _____ If yes, when? _____
Social Security Number: _____
Spouse's Name _____ Spouse's phone number: _____ Spouse's work phone: _____
In case of emergency, who should we contact? _____
Relationship: _____ Contact phone number _____
Do you have any health insurance? _____ If yes, what is the name of the insurance_____

Describe the health problem(s) you are having _____

_____

_____

_____

List Current Medicines you take: (Include eye drops, vitamins, over the counter medicines, herbals, laxatives, etc.)

_____

_____

_____

How did you obtain these medicines: _____

How tall are you? _____ How much do you weigh? _____

Do you have a personal history of any of the following?

Please answer all questions. NO Blank Spaces. If blanks, your application will not be considered.

YES	NO	CONDITION	YES	NO	CONDITION
GENERAL HEALTH			**NOSE/THROAT**		
		OVERWEIGHT			SINUS INFECTIONS
		UNDERWEIGHT			FREQUENT NOSE BLEEDS
		ANY CHRONIC ILLNESS			SORE THROAT
		POOR DENTAL CONDITION			
HEAD			**RESPIRATORY**		
		CHRONIC HEADACHES			COPD (Chronic Obstructive Pulmonary Disease)
		MIGRAINE HEADACHES			PNEUMONIA OR ASTHMA
EYES					TUBERCULOSIS OR POSITIVE TB SKIN TEST
		WEAR GLASSES OR CONTACT LENSES			OTHER LUNG PROBLEMS: (Please list):
		BLURRED VISION			SEASONAL ALLERGIES
NECK			**STOMACH**		
		THYROID PROBLEMS OR SURGERY			DIABETES
		LIMITATION OF MOVEMENT			ULCERS, STOMACH PROBLEMS, ACID REFLUX
EARS					COLITIS, IRRITABLE BOWEL SYNDROME
		EAR INFECTIONS			CHRONIC DIARRHEA OR CONSTIPATION
		HEARING LOSS			GALLBLADDER PROBLEMS

		WEAR HEARING AIDES			
YES	NO	CONDITION	YES	NO	CONDITION
HEART			**URINARY**		
		HEART DISEASE OR HEART PROBLEMS			KIDNEY STONES
		HIGH OR LOW BLOOD PRESSURE			BLADDER OR KIDNEY SURGERY
		CONGESTIVE HEART FAILURE			LEAKING OF URINE (INCONTINENCE)
		HIGH CHOLESTEROL	**EMOTIONAL**		
BLOOD					EMOTIONAL PROBLEMS
		HEPATITIS			DEPRESSION OR ANXIETY
		BLOOD CLOTS OR STROKE			CHILDHOOD SEXUAL ABUSE
		LEUKEMIA			MARITAL PROBLEMS
		ANEMIA (LOW BLOOD COUNT OR LOW IRON)	**CANCER**		
		POSITIVE HIV TEST OR AIDS			DO YOU CURRENTLY HAVE CANCER?
					HAVE YOU EVER HAD CANCER? IF YES, WHERE:

Please explain in your own words any yes answers from above:

YES	NO	CONDITION	YES	NO	CONDITION
GYNECOLOGY			**MUSCULOSKELETAL**		
		WHEN WAS YOUR LAST PAP SMEAR?			MUSCLE ACHES, PAINS, OR STRAINS
		WHEN WAS YOUR LAST MAMMOGRAM?			PHYSICAL RESTRICTIONS TO MOVEMENT
		OTHER CONDITIONS			**ALLERGIES**
		DO YOU SMOKE OR DIP TOBACCO?			FOODS:
		HOW MANY ALCHOLIC BEVERAGES DO YOU DRINK A WEEK?_____			
		DO YOU CURRENTLY USE MARIJUANA, COCAINE, HEROIN, METHAMPHETAMINES OR ANY OTHER BANNED DRUGS?			MEDICINES:

Does any member of your immediate family have any of the following?

YES	NO	CONDITION	YES	NO	CONDITION
		HEART DISEASE OR HEART ATTACK			STROKE, BLOOD CLOTS OR PHLEBITIS
		HIGH BLOOD PRESSURE			CHRONIC ILLNESSES
		KIDNEY OR BLADDER DISEASE			TUBERCULOSIS
		DIABETES			

Please explain any yes answers:

OFFICE USE ONLY:

Accepted Denied Signature: _____

Assign to: 1st year 2nd year 3rd year Specific: _____

How do you best learn new information? (Check all that apply):

___ Verbal Instruction **___ Written Instruction** **___ Demonstration** **___ Practice**

___ Other: Explain _____

_____

ASSESSMENT OF NUTRITIONAL STATUS

The purpose of this assessment is to determine if you may need the assistance of our dietician staff. Please answer the following questions and make additional comments below.

YES	NO	SOMETIMES	STATEMENT
			I am taking a multivitamin every day
			I skip meals or regularly go long periods without eating
			I have a history of eating disorders, such as bulimia or anorexia
			I am currently having problems with nausea and vomiting
			I am currently having problems with constipation or diarrhea
			I am currently having problems with leg cramps
			I am currently having problems with heartburn
			I am currently having problems with milk allergy
			I am currently following a special diet
			I am having problems with not eating enough
			I feel I need individual nutritional counseling

ADDITIONAL COMMENTS:

Are you being seen by any other physician? ___ Yes ___ No

If yes, who (Please provide name, address and telephone number) _____

_____

Signature Date Reviewed by Date

BaylorScott&White
HEALTHTEXAS PROVIDER NETWORK

Financial Assistance Confirmation

According to our records, you were approved to qualify for Baylor Scott & White HealthTexas Provider Network ("HTPN") financial assistance on _____. This form will allow us to confirm your status has not changed since your last determination and that you are still eligible to receive financial assistance in accordance with the Financial Assistance Policy. If at any time your income or insurance coverage changes, you must provide that information to HTPN in order to update your account.

Full Patient Name HTPN EPIC Account # Date of Birth

To Be Completed by Patient or Guardian:

I understand that by signing below I am stating that my income and/or insurance coverage has not changed since the date of my original application and that I may still be considered for financial assistance according to the HTPN guidelines. I also agree to inform the practice of any changes to my income and/or insurance coverage so that my status in the program can be re-evaluated.

I understand that my approved financial assistance application is effective until _____ to allow for any necessary follow up visits where applicable. At the end of that time frame I may be required to reapply for assistance.

Signature of Patient or Responsible Party

Printed Full Name Date

To Be Completed by Practice Staff:

Date of first approval Approval extension date (no more than 90 days)

Signature of Authorized Approver (Manager or Administrator) Date

Printed Name Practice Location

Baylor Scott & White HEALTH

Baylor Scott & White Health
Financial Assistance Application

Patient Account Number

Patient Name (Last, First, MI) _____ Social Security Number _____

Patient's Residential Address _____ City _____ State _____ Zip Code _____ County _____

Marital Status: ☐ Married ☐ Separated ☐ Single ☐ Divorced ☐ Widowed

Birth Date (Month/Date/Year) _____ Telephone Number _____

Spouse's Name _____

Employed ☐ Yes ☐ No

Patient's Employer _____

Telephone # _____

Employed ☐ Yes ☐ No

Spouse's Employer _____

Telephone # _____

Are the BSWH facilities you received services at the closest in network facilities to your primary residence? ☐ Yes ☐ No

If no, were the closest facilities unable or unwilling to provide your care? ☐ Yes ☐ No

If unemployed, please include the previous employer's name and telephone number*

A. *Income:* Please provide the income for each of the following persons in your household.

Patient ☐ Full Time ☐ Part Time - Hours/Week = _____

$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year

$ _____ **Additional Income**

Spouse ☐ Full Time ☐ Part Time - Hours/Week = _____

$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year

$ _____ **Additional Income**

Total Household Income $ _____

Please complete only if patient is a minor (if not leave blank)

Patient's Father ☐ Full Time ☐ Part Time - Hours/Week = _____

$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year

$ _____ **Additional Income**

Patient's Mother ☐ Full Time ☐ Part Time - Hours/Week = _____

$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year

$ _____ **Additional Income**

Total Household Income $ _____

B. *Income Verification:* Please provide verification ***(send only copies, no original documentation)*** for all sources of household income (acceptable documentation listed below). Check attached documents:

☐ Paycheck Remittance ☐ Employer Verification ☐ Credit Inquiry (completed by BSWH)
☐ IRS Form W-2 ☐ Tax Return ☐ Governmental Assistance (food stamps, CDIC, Medicaid, TANF)
☐ Bank Statements ☐ Other (describe below) ☐ Social Security, Workers Compensation or Unemployment Compensation Determination Letters

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

_____

C. *Family Members:* **Please provide the total number of people in the patient's household.**
(This number should only include the patient, patient's spouse, and the patient's dependents)

D. *Assets and Other Resources:*

Do you have any assets or other resources available to you? *(Examples include savings accounts, trusts, stocks, bonds, retirement accounts, mutual funds, etc.)*	☐ Yes	☐ No	If Yes, current amount available: $_____
Do you have medical insurance?	☐ Yes	☐ No	If Yes, please list provider name: _____
Do you have a Health Savings Account or Flexible Spending Account?	☐ Yes	☐ No	If Yes, current amount available: $_____

I understand Baylor Scott & White Health ("BSWH") may verify the financial information contained in this Financial Assistance Application ("Application") in connection with BSWH's evaluation of this Application, and by my signature hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I also authorize BSWH to request reports from credit reporting agencies and the Social Security Administration. I certify that the statements made in this Application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance.

I further understand that some physicians and providers may not be employees of BSWH. I understand that I may receive separate bills from those providers and this financial assistance application will not apply to those balances due.

_____ **Signature of Patient or Responsible Party** _____ **Printed Name** _____ **Date**

For Hospital Use Only

☐ Application information obtained by BSWH Employee in person or over the phone, no patient signature required.

_____ Electronic Signature of BSWH Employee or BSWH Representative _____ Date

Notes Regarding Income Verification/Number in the Household: _____

☐ Patient is part of community care program Program Name _____ First Statement Date: _____