



**Medical & Mental Health Services**  
315 Gill Avenue  
Knoxville, TN 37917  
865-546-7330  
InterFaithHealthCenter.org

**Dental Services**  
2607 Kingston Pike, Suite 185  
Knoxville, TN 37919  
865-243-3033

## Patient Application

Date: \_\_\_/\_\_\_/\_\_\_

How many people are in your household? \_\_\_ Total household income (before taxes): \_\_\_\_\_

Who referred you to InterFaith Health Center?

(Ex. Health Department, Hospital, ER, doctor, friend, etc.): \_\_\_\_\_

### Patient Information

First Name: \_\_\_\_\_ Middle Initial: \_\_\_ Last Name: \_\_\_\_\_

Address Line 1: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ Secondary Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: M / F / Non-Binary

Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Domestic Partnership

Race: \_\_\_ American Indian or Alaska Native \_\_\_ Asian \_\_\_ Black or African American

\_\_\_ Native Hawaiian or Other Pacific Islander \_\_\_ White

Ethnicity: \_\_\_ Hispanic or Latino or \_\_\_ Not Hispanic or Latino

Country of Birth: \_\_\_\_\_ First Language: \_\_\_\_\_

Can you read and write? \_\_\_ Yes or \_\_\_ No Do you have a translator? \_\_\_ Yes or \_\_\_ No

Do you need a translator? \_\_\_ Yes or \_\_\_ No If yes, what language? \_\_\_\_\_

### Employment Information

Are you currently employed? \_\_\_ Yes or \_\_\_ No

If yes, list place of employment: \_\_\_\_\_

Industry/Field of Work: \_\_\_\_\_ Occupation: \_\_\_\_\_

If no, list your source(s) of income: \_\_\_\_\_

If not working, list the reason: \_\_\_\_\_

If not working, list your last date worked: \_\_\_/\_\_\_/\_\_\_

If unemployed, but spouse is employed, where do they work? \_\_\_\_\_

Do you receive unemployment? \_\_\_ Yes or \_\_\_ No Do you receive disability? \_\_\_ Yes or \_\_\_ No

If you receive disability, when do you expect to receive Medicare? \_\_\_\_\_

Are you receiving Workers Comp? \_\_\_ Yes or \_\_\_ No

If yes, list the reason: \_\_\_\_\_

Do you receive Medicare? \_\_\_ Yes or \_\_\_ No If yes, what part? \_\_\_\_\_

Do you have medical insurance? \_\_\_ Yes or \_\_\_ No If yes, please see front desk.

### Emergency Contacts

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_



**Health Information**

What is the reason for your visit today?

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Please circle if you have any of these symptoms:

Change in vision	Nosebleeds	Sores in mouth	Trouble swallowing	Food getting stuck in throat	Heartburn/acid reflux/belching
Shortness of breath	Shortness of breath when lying down	Shortness of breath when going up stairs or walking	Cough	Chest pain	Coughing up phlegm everyday
Palpitations/Fast heartbeat	Abdominal pain	Bloating	Constipation	Change in bowels	Lumps or bumps of concern
Change in mole	Itching all over	Night sweats	Fever	Weight loss ___lbs	Weight gain ___lbs
Change in vaginal discharge	Change in urine	Bleeding after menopause	Discharge from penis	Snoring	Irregular breathing during sleep
Suicidal ideation	Depression	Anxiety	Sleeplessness	Elevated mood	

Please list all current medical problems and the date they began:

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Please list all previous surgeries and the dates of those surgeries:

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Please list all hospitalizations, reasons for hospitalizations and dates:

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**Medication Information**

List current medications:

Medication	Dosage (if known)	# Pills/Shots per Day

Do you take vitamins/supplements?  Yes or  No If yes, please list those below:

Vitamin/Supplement	Dosage (if known)	# Pills per Day

Do you take calcium?  Yes or  No

Are you allergic to any medications?  Yes or  No

If yes, list them: \_\_\_\_\_

**Medical History**

- When was you last Tetanus shot? / /   N/A
- When was your last TB skin test? / /   N/A
- When was your last Pneumonia vaccine? / /   N/A
- When was your COVID-19 vaccine (and booster if received)? / /   N/A
- When was your last flu vaccine? / /   N/A
- When was your last colonoscopy? / /   N/A
- When was your last prostate exam? / /   N/A
- When was your last mammogram? / /   N/A
- When was your last pap smear? / /   N/A
- Has your pap smear ever been abnormal?  Yes or  No / /   N/A
- Have you ever had treatment for an abnormal pap smear?  Yes or  No / /   N/A



**Medical History Continued**

When was you last menstrual cycle? / /   N/A

How many pregnancies have you had?   N/A

How many vaginal births?   N/A

How many C-sections?   N/A

Do you examine your breasts each month?   N/A

Are you on birth control?  Yes or  No  N/A

What is your activity level?

- Sedentary: You do less than 30 minutes a day of intentional exercise and you don't do anything that can be considered moderate or vigorous.
- Lightly Active: You do intentional exercise every day for at least 30 minutes.
- Moderately Active: You do intentional exercise every day that is equivalent to briskly walking for at least one hour and 45 minutes.
- Very Active: You do intentional exercise every day that is equivalent to briskly walking for at least four hours and 15 minutes.

Do you ever have a difficult time obtaining food?  Yes or  No

**Family Medical History:**

Do you have an immediate family history of any of the following? Please circle.

Aneurysm or Stroke	Heart attack, Bypass, or Stent	Sudden death before age 50	Blood clots, Blood disease, or Free bleeding	Kidney disease or Dialysis	Diabetes
Severe mental illness	Liver disease	Thyroid disease	Osteoporosis, Broken hip, or Hunched back	Alcoholism or Drug abuse	Melanoma
Breast Cancer	Colon cancer or Polyps	Ovarian cancer	Pancreatic cancer	Prostate cancer	Uterine cancer

Other cancer: \_\_\_\_\_

If you circled any of the above conditions, please list which condition and the immediate family member affected:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



### Social History

Do you drink alcohol?  Yes or  No

If no, please move to the next section.

Have you ever felt you should cut down own your drinking?  Yes or  No

Have people annoyed you by criticizing your drinking?  Yes or  No

Have you felt bad or guilty about your drinking?  Yes or  No

Have you ever had a drink first thing in the morning to steady your nerves, to get rid of a hangover, or as an “eye opener”?  Yes or  No

Do you consume drugs other than those required for medical reasons?  Yes or  No

If no, please move to the next section.

Have you ever felt you should cut down on your drug use?  Yes or  No

Have people annoyed you by criticizing your drug use?  Yes or  No

Have you felt bad or guilty about your drug use?  Yes or  No

Have you ever used drugs first thing in the morning to steady your nerves, to get rid of a hangover, or as an “eye opener”?  Yes or  No

Do you struggle with feelings of depression, isolation, or loneliness?  Yes or  No

Do you struggle with feelings of anxiety, increased worry, or panic?  Yes or  No

Have you have any significant life events that still worry you and you haven’t yet talked about?  Yes or  No

Would you like to speak to the with InterFaith’s mental health counselor?  Yes or  No

Do you smoke, vape, or use tobacco?  Yes or  No

If yes, please circle which one. If no, please move to the next section.

What age did you start using? \_\_\_\_\_

How many packs? (If applicable) \_\_\_\_\_

Have you ever had a sexually transmitted disease?  Yes or  No

Do you have tattoos  Yes or  No

Have you ever had Hepatitis B or C?  Yes or  No

Do you have HIV  Yes or  No

Have you ever injected drugs into your veins?  Yes or  No

Have you ever had sex with an IV user?  Yes or  No



## Statement of Privacy Practices Acknowledgement

**Please read and sign the following agreement.**

I received a copy of InterFaith Health Center's Statement of Privacy Practices.

_____	_____	___/___/___
Patient/Patient Guardian Name	Patient/Patient Guardian Signature	Date
_____	_____	___/___/___
Staff Name	Staff Signature	Date



## Medical Information Communication Consent

Please read and sign the following agreement.

**InterFaith Health Center and its staff have permission to do the following:**

Please initial on the line(s) next to your selection(s).

\_\_\_\_\_ Contact ONLY me with any test results, information, or questions at the following number(s):

\_\_\_\_\_ or \_\_\_\_\_

\_\_\_\_\_ Leave test results on my answering machine/voicemail.

\_\_\_\_\_ Leave general information or questions on my answering/voicemail.

AND/OR

\_\_\_\_\_ Speak to

\_\_\_\_\_ Leave test results

\_\_\_\_\_ Leave general information or questions

With the following people:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_  
Patient/Patient Guardian Name      Patient/Patient Guardian Signature      Date

\_\_\_\_\_  
Witness Name      Witness Signature      Date



## Consent to Treat Agreement

**Please read and sign the following agreement.**

I, \_\_\_\_\_ (Patient's First and Last Name), give permission to InterFaith Health Center to provide me with medical treatment.

**I understand that:**

Please initial both lines.

\_\_\_\_\_ I have the right to refuse any procedure or treatment.

\_\_\_\_\_ I have the right to discuss all medical treatments with my clinician.

\_\_\_\_\_  
Patient/Patient Guardian Name      Patient/Patient Guardian Signature      \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Witness Name      Witness Signature      \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date





## InterFaith Health Center Patient Agreement

**Please read and sign the following agreement.**

**I understand that:**

Please initial all lines.

- \_\_\_\_\_ I must pay my share of the costs for services I receive.
- \_\_\_\_\_ InterFaith Health Center reserves the right to discontinue medical services for any of the following reasons: multiple no-shows, non-payment of services, and/or unacceptable behavior.
- \_\_\_\_\_ I must provide financial information to requalify for services once per year.
- \_\_\_\_\_ Healthcare students might be present during my care.

_____	_____	___/___/___
Patient/Patient Guardian Name	Patient/Patient Guardian Signature	Date
_____	_____	___/___/___
Witness Name	Witness Signature	Date