InterFaith Health Center
Comprehensive Affordable Care

# Patient Application

Date: ____/____/_____
How many people are in your household? ____ Total household income (before taxes): _____
How did you hear about InterFaith Health Center? _____

**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? _____
Are you a United States veteran? ___Yes or ___No
Do you receive disability? ___Yes or ___No
If you receive disability, when do you expect to receive Medicare? _____
Do you receive Medicare? ___Yes or ___No If yes, what part? _____
Do you have medical insurance? ___Yes or ___No

**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
Are you receiving Workers Comp? ___Yes or ___No
If yes, list the reason: _____

**Emergency Contacts**
Name: _____ Phone #: _____ Relationship: _____
Name: _____ Phone #: _____ Relationship: _____

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**Health Information**

What is the reason for your visit today?

_____

_____

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:

_____

_____

_____

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

_____

_____

_____

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

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**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

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# 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 |

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# Patient 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 |

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# 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 |