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: _____
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