



## 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: \_\_\_\_\_

\*We want you to be comfortable during your visit. If you need a translator for your visit, phone calls, etc, InterFaith Health Center offers a variety of options to meet your need. We have Spanish-speaking employees if Spanish is your primary language. We also utilize a professional 'Language Line' service which makes available over 700 languages. And, if you feel more at ease, you are welcome to bring a trusted adult translator with you. Just let us know ahead of time if you plan to provide your own interpreter.

\*\*If translator is needed and patient does not have one telephonic LanguageLine will be utilized