



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 Do you have difficult time obtaining food? ___ Yes ___ 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



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:



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



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



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 services for any of the following reasons: multiple no-shows, non-payment of services, and/or unacceptable behavior.

_____ We rely on the generosity of local specialists and volunteers to provide care for our community. To respect their time and resources, we maintain a strict attendance policy. Missing a single appointment with a volunteer provider (either at InterFaith Health Center or the Specialist provider at their office) will lead to your discharge from our clinic's care. If you are unable to keep your appointment or meet your payment plan, please call both the Specialist and our clinic as soon as possible so we can assist you.

_____ 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