Islamic Society of Baltimore Community Health Center

PATIENT REGISTRATION

Please complete ALL fields

Patient Name: Last: ____________________ First: __________________ Middle: ________________

Responsible Party (Parent, if minor):

____

Home Address: ____________________________ City, State, Zip:___________________________

Home: (_____) _______________ Work: (_____) __________________ Cell: (_____)_____________

Sex: Female/Male Birthdate: _____/_____/_____ SSN: _____-______-________

Email: ____________________________________

Marital Status: Single/Married/Widowed/Other Occupation: Employed Student Unemployed

Race: American Indian/Alaskan Native Asian
Black /African American Hispanic
White Other Unknown

****

Emergency Contact:

Name: ________________________________ Contact Number: (_____)______________________

Email: ________________________________ Relation to Patient: ___________________________

****

Household Information:

Do you live in a home or an apartment? _______________________

Number of Adults ________________ Number of Children ________________

****

Social History:

Do you smoke? YES NO; If yes, how often? ____________

Do you drink? YES NO; If yes, how often? ____________

Any drugs or substances? YES NO

****

*Patient's information will be collected and/or released in accordance to HIPPA compliance & ISB Clinic's policies and procedures.

MEDICAL HISTORY

Have you previously had any of the following? Check the ones that apply:

- ☐ Asthma
- ☐ Arthritis
- ☐ Cancer
- ☐ Epilepsy
- ☐ Heart Problems
- ☐ Hormonal Problems
- ☐ Menstrual Problems
- ☐ STD
- ☐ Tuberculosis
- ☐ Allergies
- ☐ Back Problems
- ☐ Diabetes
- ☐ Gallbladder
- ☐ Hepatitis
- ☐ Lung Problems
- ☐ Pregnancy
- ☐ Stomach Problems
- ☐ Anemia
- ☐ Blood Pressure
- ☐ Anxiety
- ☐ Depression
- ☐ Other mental health problems
- ☐ HIV/AIDs
- ☐ High Cholesterol
- ☐ Menopause
- ☐ Rheumatic Fever
- ☐ Thyroid Problems
- ☐ Coronavirus

Have you had any previous surgeries or injuries? List them below:

1) ________________________________ Date:________________________________
2) ________________________________ Date:________________________________
3) ________________________________ Date: ________________________________
4) ________________________________ Date: ________________________________
5) ________________________________ Date: ________________________________

Family History

Disease/Condition	Relationship	Deceased or Alive

Immunizations

Immunizations	Date

MEDICATIONS

Name of Medication	Dosage	Frequency

DISCLOSURE OF MEDICAL RECORDS

Please list names of those whom you grant permission to receive and/or discuss your medical information with us.

Name/Relationship	Phone
____	______________________________
____	______________________________
____	______________________________
____	______________________________

COMMUNICATION CONSENT

This notice authorizes ISB Clinic to leave messages concerning appointments, lab results, etc. at the numbers you listed on your registration form, including text messages. This also authorizes us to release information concerning your health to the names listed above.

Print Name: ______________________________________

Signature ____ Date _________________

PATIENT DISCLOSURE

Islamic Society of Baltimore Community Health Center is a non-profit organization that provides primary, non-emergent and basic healthcare to the uninsured or low-income socioeconomic strata, which rely on free clinics for their well-being. The clinic accepts no reimbursement from any third-party payer (including reimbursement from any insurance policy, health plan, or federal or state health benefits program). The center treats patients without regard to age, race, color, religion, sex, national origin, handicap, or sexual preference.

The members of the medical staff practicing at the center hereby organize themselves in conformity with the byways, rules, and regulations created by the Board of Directors of the Center. The physicians volunteer at the center, and are required to abide by the ethical standards contained in the canon of ethics of the American Medical Association, or where applicable of those professional societies nationally recognized by a majority of practitioners in the same profession as those members of the medical staff who are non-physicians, and the ethical standards adopted by the Joint Commission on the Accreditation of Healthcare Organizations and/or the Accreditation Association for Primary Care Health Care.

By signing this from, I **(PRINT NAME)** _______________________ as a patient/legal guardian/health care proxy will release and forever discharge and hold harmless, all the doctors of the Center from any medical or legal claims, and any all liability, and demands of whatever kind of nature, either in law or in equity, which arise or may hereafter arise from the medical services provided to me. I understand and acknowledge that this release discharges center and the doctors from a liability or claim that you may have against the center or medical staff volunteer with respect to bodily injury, personal injury, illness, death, or property damage that may result from the medical services provided to you.

You reserve the right to read and understand the Byways, Rules, and Regulations of the Center before signing the Release and Waiver of Liability Form. You are given the opportunity to ask any questions regarding this waiver before signing it.

____
Patient Name

_____________________________________ __________________
Signature Date

PATIENT DISCLOSURE CONTD.

I (PRINT NAME), ____ am informing the ISB Community Health Center that I do not hold **ANY** insurance coverage. I acknowledge that I am uninsured, and I understand that this notice describes if I carry any type of insurance or medical coverage, then I will not be examined or treated at the ISB Community Health Center.

____

Patient Name
(or if applicable, patient representative's name)

____

Patient Signature
(or if applicable, patient representative's signature)

____

Date

PHARMACY INFORMATION

Please provide your pharmacy information:

Name: ____

Phone number: _________________________________ Fax: ___________________

Pharmacy address: ____

City, State, Zip Code: ____

Prescription refills are provided only for medications prescribed by ISB Clinic physicians. If you need a refill, please call your pharmacy, otherwise, please call our office within 48 hours prior to running out of your prescription.

Patient Name: ________________________________

Signature: ____________________________________

Date: ____