Patient Intake Form

ISB Community Health Clinic

Please complete the following form, provide all necessary signatures, and return to the front desk.
Do not hesitate to ask for assistance! Thank you!

Patient Demographics

Please complete the following fields.

Last Name: _____ First: _____ Middle Initial: _____

Date of Birth: _____ / _____ / _____ Sex: ☐ Male ☐ Female ☐ Other: _____

Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

Home Address: _____

City, State, Zip code: _____

Cell Phone: (_____) _____ - _____ Home Phone: (_____) _____ - _____

Email: _____

Emergency Contact

Please provide the following information for your emergency contact.

Name: _____ Contact Number: (_____) _____ - _____

Relationship to Patient: _____ Email: _____

Pharmacy Information

Please provide the following information for your preferred pharmacy.

Name: _____

Address: _____ City, State, Zip code: _____

Phone: (_____) _____ - _____ Fax Number: (_____) _____ - _____

Patient Health Insurance Disclosure

Please read the following information and provide your signature to indicate your understanding.

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

Patient Signature: _____ **Date:** _____ / _____ / _____

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Personal Medical History

Allergies: ☐ No Allergies

✔ Check all that apply.

Disease/Condition	Current	Past	Comments
Alcoholism/Drug Abuse			
Asthma			
Cancer (type:_____)			
Depression/Anxiety/Bipolar/Suicide			
Diabetes (type:_____)			
Emphysema (COPD)			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

Medications	Dosage	Frequency

Surgeries ☐ None

1. _____
2. _____
3. _____

Immunizations ☐ None

1. _____
2. _____
3. _____

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Family History

✔ Check all that apply.

Disease/Condition	Mother	Father	Sibling	Child	Maternal GP	Paternal GP
Alcoholism/Drug Abuse						
Asthma						
Cancer (type:_____)						
Depression/Anxiety/Bipolar/Suicide						
Diabetes (type:_____)						
Emphysema (COPD)						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Hypothyroidism/Thyroid Disease						
Renal Disease						
Migraine Headaches						
Stroke						
Other:						
Other:						

Social History

Occupation: _____ ☐ Currently unemployed

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Other: _____ Number of children: _____

Tobacco Use | Smoked Cigarettes: ☐ Yes ☐ No☐ Never Smoked	
Current: Packs/day: _____ # of years: _____	*Past:* Quit date: _____ Packs/day: _____ # of years: _____
Alcohol/Drug Use | Do you drink alcohol? ☐ No ☐ Yes, # of drinks/week: _____	
Do you use marijuana or recreational drugs? ☐ Yes ☐ No | Have you ever used needles to inject drugs? ☐ Yes ☐ No	
Have you ever taken someone else's drugs? ☐ Yes ☐ No	

Patient Signature: _____ **Date:** _____ / _____ / _____

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ISB Community Health Clinic

Release and Waiver of Liability

Please read the following and provide your signature to serve as your acknowledgement and understanding. Please see the front desk staff for any questions, comments, or concerns you may have.

The Islamic Society of Baltimore Community Health Clinic 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 form, I,_____**,** as a patient/legal guardian/health care proxy will
PRINT NAME
release, forever discharge, and hold harmless, all the physicians of the Islamic Society of Baltimore Community Health Clinic from any medical or legal claims, any and 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 the center and the doctors from a liability or claim that you may have against the Islamic Society of Baltimore Community Health Clinic, physicians, staff, and volunteers 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 Islamic Society of Baltimore Community Health Clinic before signing the Release and Waiver of Liability agreement. You are given the opportunity to ask any questions regarding this waiver before signing it.

Print Name: _____

Patient Signature: _____ **Date:** _____ / _____ / _____

Patient Intake Form

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Disclosure of Medical Records

By listing names of those whom you grant the Islamic Society of Baltimore Community Health Clinic permission to receive and/or discuss your medical information, you are giving your consent to disclose your medical records with the listed parties upon your request.

Name	Relationship to Patient	Contact Number

Print Name: _____

Patient Signature: _____ **Date:** _____ / _____ / _____

Communication Consent

☐ I authorize the Islamic Society of Baltimore Community Health Clinic to leave voicemails and or text messages concerning appointments, testing results, etc. at the numbers listed on this registration form.

☐ I do not authorize the Islamic Society of Baltimore Community Health Clinic to leave voicemails and or text messages concerning appointments, testing results, etc. at the numbers listed on this registration form.

Print Name: _____

Patient Signature: _____ **Date:** _____ / _____ / _____

Please ensure all fields of this form have been completed before returning to the front desk with a valid ID.