CHURCH HILL medical mission
a mission of Of One Accord Ministry

Date Updated: ___ / ___ / _____

Patient Application

Full Name: _____ **Preferred Name** _____

Date of Birth: ___ /___ /_____ **Age:** ____ **Social Security #:** _____**Gender:** M / F

Street Address: _____ **County:** _____

City: _____**State:** _____**Zip:** _____

Phone: _____ Home / Cell **Secondary Phone:** _____ Home / Cell

Emergency Contact Name: _____

Relationship to you? _____***Phone:*** _____

Circle Marital Status: Single / Married / Divorced / Widowed / Separated

Circle Ethnicity: White / African American / Hispanic / Native American / Asian / Other

Circle if you are a Veteran: Yes / No **US Citizen:** Yes / No **US Resident:** Yes / No

Circle Employment Status: Part Time / Seasonal / Unemployed / Not in Labor Force / Retired / Full

Occupation: _____ **Employer:** _____

Are you any of the following? Homeless/ Living in Shelter/ Home Insecure/ None of these

Highest Education Level Achieved: Elementary / High School / Graduated High School / GED / College / Some College / College Graduate / Master's Degree / Doctorate

Primary Language: English / Spanish / Other: _____**Interpreter needed?** Yes / No

Do you have medical insurance? Yes / No **If yes, insurance company:** _____

If yes, do you have a co-pay or deductible: Yes / No **If yes, how much?**: _____

Do you have a regular doctor? Yes / No_____ **If yes, who?** _____

When was your last physical exam? _____

Do you see a mental health counselor? Yes / No **If yes, who?** _____

Circle any that you receive? SSI or Disability / Families First / Unemployment / None of these

What is your yearly income? Under $10,000 / $10,000-$14,999 / $15,000-$19,999 / $20,000-$24,999 / $25,000-$29,999 / $30,000 or higher

How many people are in the home? _____ Adults _____ Children

Which of the following health problems does your mother, father, sister, or brother have/had?

Heart disease / High blood pressure / Pre-diabetes / Diabetes / Cancer / Depression / Mood disorders

Do you have allergies to any medications or foods? Yes / No

If yes, please list medicine/food allergen(s) and describe your reaction: _____

_____

_____

_____

_____.

Church Hill Medical Mission, P.O. Box 166, Church Hill, Tn 37642 Phone: 423-256-2408 Fax: 423-256-2426

Church Hill Medical Mission does Charge a $10.00 Fee and does accept donations.

Patient Name: _____**DOB**___/____/___

Circle Childhood Illness you have had. Chicken Pox / Measles / Mumps / Polio / Rheumatic Fever / Rubella / Scarlet Fever / Other _____

Did you receive routine childhood immunizations required to attend school? Yes / No

List Hospitalizations: (Include location)_____

_____

Past Surgeries: (Include procedure and year) _____

_____

Please read the list below and circle any health conditions that you have or have had:

Anxiety	Epilepsy or Seizures	Lung Disease	Do you use:
Arthritis	GERD or Acid Reflux	Migraines	Alcohol y/n
Blood Clot	Heart Attack (MI)	Mood Disorder	Tobacco y/n
Cancer	Heart Failure	Nerve Disease	Recreational Drugs y/n
Decreased Hearing	High Blood Pressure	Stroke or TIA	
Decreased Vision	High Cholesterol	Thyroid Disease	
Depression	Kidney Disease	Ulcer	
Diabetes or Pre-diabetes	Insomnia	Other _____	

Please list all medications, vitamins, supplements, or over the counter products you currently take:

Medication name and strength	How often you take it	The reason you take it

Patient Name:_____ DOB: __/__/__

Immunizations	**Date**	**Date**	**Date**
COVID-19			
Influenza			
Pneumococcal			