Charis Health Center
Mt. Juliet Office
2620 N. Mt. Juliet Rd.
Mt. Juliet, TN 37122

Charis Health Center
Gladeville Office
9000 Stewarts Ferry Pk
Mt. Juliet, TN 37122

Today's Date_____

Last Name_____ First Name_____

Middle Name_____ Preferred Name_____

Male_____ Female _____

Date of Birth_____

Address_____

City/State/Zip_____

Home Phone_____ Cell Phone_____

Email_____

Language _____

Race

- ❑ White
- ❑ Black/African American
- ❑ Hispanic
- ❑ Asian
- ❑ Other
- ❑ Patient Declined

Ethnicity

- ❑ Hispanic/Latino
- ❑ Not Hispanic/Latino

- ❑ Married
- ❑ Single
- ❑ Divorced
- ❑ Other
- ❑ Child

If minor child, guardian signature_____

How did you hear about Charis?_____

Emergency Contact

Name_____

Address_____

City/State/Zip_____

Phone_____ Relationship to patient_____

CHARIS HEALTH CENTER

MEDICAL HISTORY FORM

Date_____

Name_____ Date of Birth _____

List all the medications that you are currently taking (prescription and over the counter), dosages, frequency:

_____ _____
_____ _____
_____ _____

Allergies _____ Severity: Mild Moderate Severe Reaction: _____
_____ Severity: Mild Moderate Severe Reaction: _____
_____ Severity: Mild Moderate Severe Reaction: _____

Surgeries _____ Have you ever had a blood transfusion? _____
_____
_____

Hospitalization History

Have you ever been hospitalized for anything other than surgeries? _____ If yes, please explain
_____

Have you ever been diagnosed with the following?

- ❑ Diabetes
- ❑ Tuberculosis
- ❑ Heart Disease
- ❑ Gastrointestinal Disease
- ❑ Thyroid Disease
- ❑ Abnormal Pap Smears/Cervical treatment
- ❑ High Blood Pressure
- ❑ Endometriosis
- ❑ Respiratory Disease
- ❑ Cancer
- ❑ MSK Disorder

Do you have any family history of the following? If yes, please explain.

- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Heart Disease
- ❑ Cancer
- ❑ Tuberculosis
- ❑ Autoimmune disease
- ❑ Other _____

Do you use any of the following?

Cigarettes _____ if yes, how much/often? _____
Alcohol _____ if yes, how much/often? _____
Recreational Drugs? if yes, how much/often? _____

Any Diet? Please explain _____
Exercise? How often _____

CHARIS HEALTH CENTER

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the Charis Health Center to release my protected health information, if necessary, to the people named below. The purpose is to inform the patient or others in the keeping with the patient's instructions.

I understand that Charis Health Center may need to discuss my medical conditions and may need to share my medical condition and may need to share my medical records with any physician, physician extender, nurse, therapist or other healthcare provider who is involved in my care.

	Yes	No
Charis has my consent to call for appointment reminders on my cell phone, home phone or answering machine	___	___
Charis has my consent to text upcoming appointment reminders to my cell phone	___	___
Charis may leave messages for appointment reminders with others in my home	___	___
I give Charis permission to talk to the person(s) listed below about my medical condition and/or test results .	___	___

Name_____ Phone Number _____

Name _____Phone Number _____

Interpreter
Signature _____ Print Name _____ Date _____

CONSENT TO TREAT

I hereby voluntarily consent to medical examinations, treatment and procedures which are deemed necessary in the opinion of my healthcare providers, including HIV tests, laboratory tests, and x-rays.

I understand my medical information is strictly confidential and is protected by the Tennessee law and no guarantees or warrantees have been made to me concerning the results of the examinations, treatment or procedures.

My signature acknowledges that I have been given the opportunity to ask questions about this consent form and that I have the availability to refuse services.

Signature_____ Date_____

RIGHTS OF THE PATIENT

I understand that i have the right to change this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed in this document by sending written notifications to:
Clinic Director, Charis Health Center, 2620 N. Mt. Juliet Rd. Mt. Juliet, TN 37122

I understand any change in this authorization is effective from the date signed going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal or state law.

I understand that I have the right to refuse this authorization and that my treatment will not be conditioned upon signing. This authorization shall be in effect until revoked by the patient.

Signature _____ Date_____

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VERIFICATION FORM

Last Name _____

First Name _____ Middle Name _____

I verify that:

☐ I **do not** have health insurance of any kind

☐ I am a resident of _____ County

☐ I am employed at _____
- ☐ Full time
- ☐ Part time

☐ I am unemployed

☐ I am a veteran

☐ I **am not** a veteran

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Rev. 11/01/17