FAITH FAMILY
MEDICAL CENTER

Date:	

Please complete this form to the best of your ability and as completely as possible. All of the requested information is needed to provide you and your family with medical care at our Center.

APPLICANT INFORMATION

First Name	MI	Last Name	Date of Birth	Sex	Marital Status
				M F	

Mailing Address: Street	City	State	Zip	Primary Phone #

Social Security Number	Email Address	Employer Name & Address

Employer Phone	Hours Worked Weekly	Average Monthly Earnings	I work: (Circle One)	
			Full-time	Part-time

SPOUSE INFORMATION (If applicable.)

First Name	MI	Last Name	Date of Birth	Sex	Marital Status

Home Address: Street	City	State	Zip	Home Phone #

Social Security Number	Employer	Employer Address

Employer Phone	Hours Worked Weekly	Average Monthly Earnings	I work: (Circle One)	
			Full-time	Part-time

DEPENDENTS (Must be living with you in your home.)

Name	Age	Birth Date	Social Security Number
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Do you have health insurance? Yes No
Are you covered by Medicaid, TennCare (Medicare), or TriCare insurance? Yes No
Do you have an Advanced Directive? Yes No

PLEASE COMPLETE BACK SIDE OF FORM.

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Have you signed up for our new complimentary* text reminders regarding your appointment?

Our new texting service is designed to help you with important information regarding your appointment:

- Notify you in advance of your upcoming appointment.
- Notify you of changes in our clinic hours (i.e., due to severe weather).

The system is set up for two-way communication, meaning you are able to text the Center if there is a problem with your appointment, if you prefer not to call.

Please check the box and fill in the blanks.

1. I would like to sign on to your texting service (check box) ☐
2. Name _____
3. Mobile number _____
4. Date_____

IF THERE ARE ANY PARTICULAR PERSONS YOU WOULD ALLOW TO RECEIVE YOUR MEDICAL INFORMATION, PLEASE INDICATE BELOW:

_____ _____

_____ _____

Whom may we contact in case of an emergency?

Name_____ **Phone** _____

The information I have provided on this form is true and accurate to the best of my knowledge. I understand that Faith Family Medical Center furnishes care only to those individuals that qualify for services under the Center's guidelines regarding health insurance status, family income, and family size. I understand that if I am accepted for care at the Center, I will be responsible for an affordable co-payment for each visit made to the Center by myself and/or a member of my immediate family. If I am accepted by the Center, I agree to follow all the Center regulations and guidelines.

Your Signature **Date**

I have been offered a copy of Faith Family Medical Center's Notice of Privacy Practices for my own records.
Initials:_____

How did you hear about Faith Family Medical Clinic? _____

_____

_____

*Standard data and messaging rates may apply.