MEMPHIS MUSLIM MEDICAL CLINIC
a project of
Memphis Muslim Medical Services, Inc.
1055 Stratford Road, Memphis, TN 38122 • Phone: (901) 685-3901 • Fax: (901) 685-3903
www.muslimclinic.org

PATIENT REGISTRATION FORM

Date: _____ **MRN (Office Use Only):** _____

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Sex: ____ Preferred Language(s): _____

Ethnicity/Race: _____ Refugee Status (Y/N, current or former): _____

Religion: _____ Social Security #_____ Marital Status: _____

Employment Status: ___Full Time ___ Part Time ___ Unemployed ___Retired ___ Disabled

Occupation: _____ Employer Name: _____ Phone # _____

Employer Address: _____

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Responsible Party (If someone other than the patient)

Name: _____ Relationship to patient: _____

Social Security # _____ Home Phone: _____ Cell Phone: _____

Address: _____ Email: _____

Other Information

Primary Care Provider: _____ Phone # _____

Address: _____

Preferred Pharmacy: _____ Phone # _____

Pharmacy Address: _____

Referred By: _____ How did you hear about us? _____

Name of the person completing this form (if other than patient)? _____

(Form continued on next page)

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PATIENT'S MEDICAL/SOCIAL HISTORY

Date: _____ **MRN (Office Use Only):** _____

Last Name: _____ First Name: _____ Middle Initial: _____

Personal Medical History

Medications you currently take (including vitamins, herbals, and supplements)

_____

_____

Vaccinations that you have received (e.g., Hepatitis A/B, MMR, TDaP, Pneumonia, Influenza, COVID-19, etc.)

_____

_____

Chronic medical problems that other doctors have diagnosed

_____

_____

Any surgeries or other hospitalizations

_____

_____

_____

Any allergies to medications, food or environmental/seasonal

_____

_____

Do you have Medical Insurance? Y/N Name of Insurance Company: _____

Do you have a living will or advance directive? Y/N Are you interested in learning more? Y/N

Family History

List any medical issues that are present in your family and relationship of the person affected.

_____

_____

_____

_____

(Form continued on next page)

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Date: _____ **MRN (Office Use Only):** _____

Last Name: _____ First Name: _____ Middle Initial: _____

Social History

Tobacco use? Y/N If yes, how many packs/day and for how many years? _____

Alcohol use? Y/N If yes, how many drinks/day, type of alcohol, and for how long? _____

Drug Use? Y/N If yes, what drug, route of use, and for how long? _____

Sexual History: Are you currently sexually active? Y/N If yes, how many partners and gender?_____

In what type of housing do you live (circle one)? Apartment, rental property, own house, homeless, other___

With whom do you live currently (circle one)? Alone, spouse, family, relative(s), partner, other _____

Number of individuals who live in your household ____

What is you current family income?

___ <$20,000 ___ $20,000 - $30,000 ___ $30,000 - $40,000 ___ $40,000 - $50,000 ___ >$50,000

Are you Zakat eligible? Y/N

Healthcare Challenges

Please place an X by any of the healthcare challenges listed below that you may face.

____ Appointment availability
____ Access to care
____ Cost of speciality care
____ Transportation
____ Lack of healthy food options
____ Employment
____ Discrimination
____ Exposure to mass media (cell phone/internet)
____ Language services
____ Cost of medications
____ Cost of insurance
____ Distance to the clinic
____ Opportunities to exercise
____ Social support
____ Exposure to crime/violence
____ Disease education

I _____ (patient name) attest that the information that I have provided above is true and accurate to the best of my knowledge. I agree to pay the required patient provider visit, and, if needed, lab fees to the Memphis Muslim Medical Clinic (MMMC) and will inform the clinic staff if I need assistance with payment. I understand that any referrals to non-MMMC providers including but not limited to medical specialists and for imaging and diagnostic services are contingent on acceptance by the specialist provider and/or imaging and diagnostic service and that the MMMC may not cover any or all fees charged by the specialist provider or imaging or diagnostic service. I agree to promptly update the Memphis Muslim Medical Clinic should any of the aforementioned patient information change.

Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE - OFFICE USE ONLY

Date Received: _____ Accepting Staff Name: _____

New Patient: _____ Returning Patient: _____ Annual Update: _____ Patient MRN: _____