M-POWER Ministries Health Center
4022 4th Avenue South
Birmingham, AL 35222
205.595.5959
205.595.5974 fax

I. PATIENT INFORMATION

Last Name	First Name	Middle Name/Initial	Suffix

Date of Birth	Gender	Maiden Name	Social Security Number

Home Address (House Number and Street)	City	State	Zip Code

Home Phone	Work Phone	Mobile Phone

Email Address	Photo ID#	Photo ID Type	County

Country of Birth	Primary Language Read	Primary Language Spoken

Emergency Contact	Phone Number	Relationship to Patient

RACE	ETHNICITY	MARITAL STATUS
☐ *Declined to specify	☐*Declined to specify	☐* Declined to specify
☐ Afro American	☐ Hispanic/Latino	☐ Unknown
☐ Asian	☐ Not Hispanic/Latino	☐ Single
☐ Caucasian	☐ Unknown	☐ Married
☐ Hispanic	☐ Other	☐ Widowed
☐ Native American		☐ Divorced
☐ Native Hawaiian		☐ Other
☐ Pacific Islander		

Date: ______________________________

Chart #: ______________________________

II. EMPLOYMENT INFORMATION

Employer Name ______ Employment Status ______ Class of Work ______

Job Title ______ Length of Time on Job ______ Type of Income/Proof ______

Employer Offers Health Insurance (Yes/No) ______ Date Last Worked ______

III. HOUSEHOLD INFORMATION

Household Size ______ Household Annual Income ($) ______ Patient Annual Income ($) ______

Education in Years ______ Transportation Mode ______ Housing Type ______

Support Person's Name ______ Relationship to Patient ______

Guardian's Name ______ Relationship to Patient ______

Is Support Person translating on behalf of patient? ☐Yes ☐ No

☐ Veteran ☐Disabled

☐ Female Head of Household

IV. INSURANCE INFORMATION

☐ I am currently not insured.

☐ I am currently insured.
Name of Insurance Company: ______

Attest:

By signing this form, I am stating that all information being provided to M-POWER Ministries is to my knowledge true and accurate. I understand that if any information is found to be false or inaccurate, it could jeopardize my ability to receive any services provided by M-POWER Ministries.

Patient Signature ______ Date ______

PATIENT ACKNOWLEDGEMENT OF HIPAA:
RECEIPT OF NOTICE OF PRIVACY PRACTICES
AUTHORIZATION OF RELEASE FORM

I have been given a copy of the M-POWER Ministries Health Center Notice of Health information Practices that describes how my health information is used and shared. I understand the Clinic has the right to change this notice at any time. I may obtain a current copy of the notice at any time by contacting M-POWER Ministries Health Center. My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Health Information Practices.

Please list any other parties who can have access to your health information:

☐ Name: ______________________ Relationship to Patient: ______________

Phone Number: ______________

☐ Name: ______________________ Relationship to Patient: ______________

Phone Number: ______________

☐ Name: ______________________ Relationship to Patient: ______________

Phone Number: ______________

______________________ ______________________
Name of Patient (Please print) Signature of Patient (or legal representative)

____
Date

Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergent situation prevented from obtaining the acknowledgement
☐ Other. Please specify below:

____

____
Staff Member's Name

______________________ ______________________
Staff Member's Signature Date

Please remember to indicate in EMR that form has been signed and received.

M-POWER HEALTH CENTER

CONSENT TO PHOTOGRAPH, FILM OR VIDEOTAPE A PATIENT FOR NON-PROFIT USE

(e.g., educational, public service or program promotion purposes)

Patient Name (Print) ______________________________

I hereby consent to the participation in interviews, the use of quotes, and the taking of photographs, movies, or video tapes of the Patient named above by M-POWER Health Center (MPHC).

I also grant the right to edit, use and reuse said products for non-profit purposes including use in print, on the internet, and all other forms of media. I also hereby release the MPHC and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

Signature ____ Date ________________________

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I. MEDICAL HISTORY

Date ______________________

Please list all known drug allergies:

____

____

Please list any other allergies:

____

Family History: Please list serious medical conditions of immediate family members below:
Example: Mother, lung cancer

____

____

____

Do you have now or have you ever in the past had any of the following medical conditions?

___ Allergies
___ Anemia
___ Anticoagulation
___ Arthritis
___ Asthma/COPD
___ Bleeding
___ Blood Plasma
___ Bowel Disease

___ Depression
___ Diabetes
___ Diarrhea
___ Eye Disease
___ Epilepsy
___ GERD
___ Gout
___ Heart Disease

___ Hyperlipidemia
___ Hypertension
___ Kidney Disease
___ Liver Disease
___ Major Blood Vessel Disease
___ Mental Illness
___ Multiple Sclerosis

___ Migraines
___ Nerve Disease
___ Obesity
___ Osteoporosis
___ Stroke
___ Thyroid
___ Transfusions
___ Cancer
Type: ______________

___ AIDS/HIV
___ Cholera
___ Chicken Pox
___ Dengue
___ Ebola
___ Encephalitis

___ Filariasis/Encephalitis
___ Guinea Worm
___ Hepatitis
___ Malaria
___ Measles
___ Mumps

___ Parasite Infection
___ Poliomyelitis
___ Rheumatic Fever
___ Scarlet Fever
___ Tetanus
___ Trachoma

___ Tuberculosis
___ Whooping Cough
___ Venereal Disease(s)/ Sexually Transmitted Diseases
Type: ______________

Patient Name ______________________________

Date of Birth ______________________________

II. Current Medications

Please list current medications including strength and time of day medication is taken:

____

____

____

Please list the dates and types of any surgeries:

____

____

____

Please list the dates and types of any hospitalizations:

____

____

____

III. Social History

Do you smoke:	Yes/No	Rarely	Moderate	Daily	Quit
If yes, how many packs per day?	_______				
Do you drink alcohol:	Yes/No	Rarely	Moderate	Daily	Quit
Do you use drugs:	Yes/No	Rarely	Moderate	Daily	Quit
Do you exercise:	Yes/No	Rarely	Moderate	Daily	Quit

IV. FAMILY MEDICAL HISTORY

	Father	*Mother*	*Paternal Grandfather*	*Paternal Grandmother*	*Maternal Grandfather*	*Maternal Grandmother*
Age, if alive						
Age at Death						
Cause of Death						
Asthma						
Heart Disease						
Hypertension						
Stroke						
Cancer						
Colon cancer						
Glaucoma						
Diabetes						
Epilepsy						
Stomach Ulcer						
Kidney Disease						
Arthritis						
Alcohol						