M-POWER MINISTRIES HEALTH CENTER

4022 4th Avenue South
Birmingham, AL 35222
205-582-1484
205-582-1476 español
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

How did you hear about M-POWER?

RACE	ETHNICITY	MARITAL STATUS
☐ *Declined to specify	☐ *Declined to specify	☐ * Declined to specify
☐ African 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 _____

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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.

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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	___ Depression	___ Hyperlipidemia	___ Migraines
___ Anemia	___ Diabetes	___ Hypertension	___ Nerve Disease
___ Anticoagulation	___ Diarrhea	___ Kidney Disease	___ Obesity
___ Arthritis	___ Eye Disease	___ Liver Disease	___ Osteoporosis
___ Asthma/COPD	___ Epilepsy	___ Major Blood	___ Stroke
___ Bleeding	___ GERD	Vessel Disease	___ Thyroid
___ Blood Plasma	___ Gout	___ Mental Illness	___ Transfusions
___ Bowel Disease	___ Heart Disease	___ Multiple Sclerosis	___ Cancer
			Type: _____

___ AIDS/HIV	___ Filariasis/Encephalitis	___ Parasite Infection	___ Tuberculosis
___ Cholera	___ Guinea Worm	___ Poliomyelitis	___ Whooping Cough
___ Chicken Pox	___ Hepatitis	___ Rheumatic Fever	___ Venereal Disease(s)/
___ Dengue	___ Malaria	___ Scarlet Fever	Sexually Transmitted
___ Ebola	___ Measles	___ Tetanus	Diseases
___ Encephalitis	___ Mumps	___ Trachoma	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						