Empowered Health
6801 Belair Road
Baltimore, MD 21206

Ph: 443-372-7890
Fax: 929-363-0205

Patient Legal Name: ____

Preferred Name: ____ __________________________________Date of Birth: _________________

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐Divorced ☐ Widowed ☐ Separated

Address: ____ ☐ I do not have a permanent address

City/State/Zip Code: ____

Phone: _______________ ☐This phone receives texts Work Phone: _____________________

Email Address: ____

How should we contact you? ☐Home ☐ Phone ☐ Cell Phone ☐ Work ☐ Phone ☐ Text ☐ Mail ☐ E-mail

Birth/Legal Sex: ☐ MALE ☐ FEMALE Social Security Number: ______________________________

Current care provider: ____

Phone Number: _______________________ ☐ I do not have a current care provider

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In an effort to know more about the people we serve, we would appreciate the following information:

Preferred language (if other than English): ____

Race: ☐ Black/African American ☐ White/Caucasian ☐Asian ☐Native Hawaiian ☐ Pacific Islander

☐American Indian/Alaskan Native ☐More than one race ☐Other ☐ Decline to State

Ethnicity: ☐ Hispanic/Latino ☐Non-Hispanic/Latino ☐ Decline to State

Household Income: Total yearly income: _____________ Number of people in household: __________

☐ I am a Veteran

Sexual Orientation: ☐ Straight/Heterosexual ☐Lesbian/Gay/Homosexual ☐Bisexual

☐ Choose not to disclose ☐ Other: ____________________________

Current Gender Identity: ☐Male ☐ Female ☐ Gender Queer ☐ Other: __________________

☐ Transgender Male/Transman/FTM ☐ Transgender Female/Transwoman/MTF

☐ Choose not to disclose

Pronoun Preference: ☐ Male ☐ Female ☐ Other: __________________

Employer: ____

Employer Address: ____

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Emergency Contact Name: ____
Phone Number: ___________________________ Relationship: _________________________________
Special Needs such as a wheelchair, interpreter, or ambulance transportation, etc?: ☐ YES ☐ NO

If yes, please explain: ____

I certify that the information contained herein is accurate. If any information changes, I will notify Empowered Health.

Patient Signature (if over 18): _______________________________________ Date: ________________

Parent/Guardian Signature: ____ Date: ________________
Parent/Guardian Name: ____

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PATIENT MEDICAL HISTORY FORM

Patient Legal Name: ____________________________________Date of Birth:____________________
Preferred Name: ____

Please complete this entire form to help us provide the best care possible. This information is for your health care provider only and will be kept confidential.

1. Personal Medical History

Medical Problems (high blood pressure, diabetes, asthma, etc.)

______________________ ______________________ _______________________
______________________ ______________________ _______________________

Psychiatric Problems (depression, anxiety, bipolar disorder, etc.)

______________________ ______________________ _______________________

Hospitalizations/Surgeries

____Date_________________________
____ Date_________________________
____Date_____________________________

Medications (include herbal, vitamins, and supplements)

Name	Dosage	Name	Dosage
______________________	__________________	_____________________	___________________
______________________	__________________	_____________________	___________________
______________________	__________________	_____________________	___________________

Allergies

______________________ ______________________ _______________________

2. **Family Medical History**

Has anyone in your family had any of the following medical problems? (check all that apply)

☐Diabetes	☐ High Blood Pressure	☐ Heart Disease/Heart Attack
☐Stroke	☐ High Cholesterol	☐ Kidney Disease/Dialysis
☐Asthma	☐ Migraine Headaches	☐ Breast Cancer
☐Colon/Intestine/Anal Cancer	☐Other Cancer(s) (Type: __________________________________)	

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Please fill in the details below:

	Living or Deceased	Current Age/Age at Death	Medical Problems
Mother			
Father			
Sibling _			
Sibling			
Grandparent _			
Grandparent			
Grandparent			
Grandparent			

3. Preventive Care – When was your last…

	Date	Normal/Abnormal		Date
Mammogram	___________________	_____________________	Flu Shot	______________________
Pap Smear	___________________	______________________	Pneumonia Shot	________________
Colonoscopy	___________________	______________________	Tetanus Shot	_________________
HIV Test	___________________	______________________	Shingles Vaccine	________________
Cholesterol Test	___________________	__________________	HPV/Gardasil Vaccine	___________
Eye Check-Up	___________________	___________________	Hepatitis Vaccine	________________

Please make sure to complete a Release of Information (ROI) for the offices/providers that have these records.

4. Social History Do you smoke? ☐ YES ☐ NO If you quit, when was that? _______________________

How much alcohol do you drink and how often? ____

Do you use illicit drugs? ☐ YES ☐ NO If you quit, when was that? ________________________________

If you have ever used drugs, please list what types and how often: ________________________________

Do you exercise? ☐ YES ☐ NO If yes, what do you do and how often? __________________________

____

Who do you live with? ____

Are you working? ☐ YES ☐ NO Occupation: ____

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Highest level of Education: ____

Have you ever been abused? ☐ YES ☐ NO

____

____

Do you have a: ☐ Living Will ☐ Medical Advanced Directive ☐ Psychiatric Advanced Directive

5. Sexual History

How many sexual partners have you had: this month __________ this year _________ in your lifetime_________

What is your sexual orientation? ☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual

☐ Other: ____________________________

My sexual partners are: ☐ Male ☐ Female ☐ Both

Do you use condoms? ☐ Always ☐ Sometimes ☐ Never

If you or your partner use birth control, what kind? ____

Have you ever had an STD (sexually transmitted disease? ☐ YES ☐ NO

If yes, what kind? _____________________________

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PATIENT ACKNOWLEDGEMENT FORM

Patient's Financial Responsibility and Permission to Release Medical Billing Data Related to a Claim

I hereby accept financial responsibility to pay Empowered Health all amounts not covered by my health plan, including amounts for copayments, coinsurance, fee scale payments, deductibles, non-covered services and services for which I have not received a proper authorization or a referral. In addition, I accept financial responsibility for any health care benefits that are denied because I am not eligible to receive those benefits at the time of service.

I understand that Empowered Health accepts payment by cash, credit card, money order or check. Payment is generally required for all services at the time the services are rendered, although Empowered Health reserves the right to later send you an invoice for health benefits that may be denied by your health plan.

I authorize my health plan to make payment to Empowered Health for services rendered. I also authorize Empowered Health to use and disclose my health information as necessary to obtain payment. I understand that Empowered Health will hold me financially responsible if I choose not to have my health plan cover a service. If my health plan is subject to ERISA, I authorize Empowered Health to act on my behalf to obtain payment for benefits. I also authorize Empowered Health to appeal any denial of services or benefits by any health plan on my behalf. If my account is sent to a collection agency for non-payment, I agree to pay all reasonable fees that are charged to collect the outstanding amount that is due to Empowered Health, including reasonable attorney's fees, interest and court costs.

General Consent to Treatment

I, or my legal representative on my behalf, agree to have Empowered Health's health care practitioners provide evaluation and treatment for my condition, injury or illness.

Acknowledgement

By signing below, I acknowledge that I have carefully reviewed this form, have had the opportunity to ask questions, and voluntarily agree to its provisions.

Patient Legal Name or Legal Representative(printed): ______________________________DOB: ________

Patient Preferred Name: ____

Signature of Patient or Legal Representative: _____________________________Date: ______________

* A copy of this Acknowledgement is available upon request.