



"Serving people regardless of the ability to pay"

**PATIENT INTAKE FORM**

Initial Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Patient ID #: \_\_\_\_\_

Mother's Maiden Name? Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_ S.S. #: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female  Transgender ( M to F or  F to M)

Marital Status:  Married  Single  Divorced  Widowed  Partnered

Race:  White  African American  American Indian or Native American  
 Asian Pacific Islander  Other: \_\_\_\_\_

Ethnicity:  Hispanic  Non-Hispanic

What is your preferred language:  English  Español  Kreyol  Other: \_\_\_\_\_

**PATIENT CONTACT INFORMATION**

Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

City State Zip Code

Home Telephone Number: \_\_\_\_\_ Alternate Contact: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Is it ok to contact you?  Yes  No

EMAIL ADDRESS: \_\_\_\_\_@\_\_\_\_\_

TEXT Contact Number: \_\_\_\_\_

Best Contact for Appointment?  Mail  E-mail  Cell phone call  Cell phone text

Yes  No Is it OK to contact me for alerts, administrative updates, health information and health promotions, health fair invites, and other social events and announcements.

**INCOME INFORMATION**

Employment:  Yes  No If yes, how long? \_\_\_\_\_ Disabled?  Yes  No If yes, how long? \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

City State Zip Code

Employer Contact Number: \_\_\_\_\_ Annual Income: \_\_\_\_\_  
 (Check Stub, W2, Disability, etc.)

Student:  Yes  No If yes, what grade level? \_\_\_\_\_ Household Size: \_\_\_\_\_

School Name: \_\_\_\_\_ Is your vaccine record current?  Yes  No  Unknown

If you are a minor this Form Must Be Completed by Parent/Legal Guardian



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**EMERGENCY CONTACT INFORMATION**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code

Telephone Number: \_\_\_\_\_ Other Phone: \_\_\_\_\_

How did you hear about our practice?  Family  Friend  Patient  Radio  Flyer/Card

Other: \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance**

Plan Name: \_\_\_\_\_

I.D. Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ S.S. #: \_\_\_\_\_

**Secondary Insurance**

Plan Name: \_\_\_\_\_

I.D. Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ S.S. #: \_\_\_\_\_

*It is the policy of the health center to serve all patients regardless of the inability to pay.*

*Individuals and families who have income less than 200% of the Federal Poverty Level may apply for the Sliding Fee Discount Program (SFDP). Individuals and Families who are eligible will pay for service rendered based on the Sliding Fee Discount Schedule (SFDS). You must complete the application and have all required documents at the time of service to be eligible for the program or you will be charged/or service based on the health center's fee schedule. Patient who require emergency service will be assessed by the Medical Director or his/her designee.*

If you are a minor this Form Must Be Completed by Parent/Legal Guardian





Building a Healthy Community

**Empower "U", Inc.**

Community Health Center

"Serving people regardless of the ability to pay"

**INFORMED CONSENT FOR RECEIVING TREATMENT**

I, \_\_\_\_\_, \_\_\_\_\_  (Patient) or  (Parent or Guardian of minor child) do hereby voluntarily consent to the rendering of medical care, including diagnostic procedures and medical treatment, by authorized members of the Empower "U", Inc. Community Health Center (EUCHC) clinical staff or their designees, as may be in their professional judgment necessary. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on me.

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to EUCHC. I acknowledge that I am financially responsible for the payment whether or not covered by insurance.

**I have read this form and certify by signing below that I understand its contents and have been given explanation of the benefit and risks of treatment.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**CONSENT FOR TO SHARE PHI WITH DESIGNATED INDIVIDUALS**

I give consent to Empower "U", Inc. CHC the authority to discuss my health information with the following individuals:

Name	Relationship	Phone Number	May we leave a voice mail
1.	Parent/Legal Guardian		
2.			
3.			

\_\_\_\_\_  
Patient or Parent/Legal Guardian Signature

\_\_\_\_\_  
Witness Signature

**(If, the patient being treated is under 18 years of age Parent or Legal Guardian's Consent is required for treatment)**

If you are a minor this Form Must Be Completed by Parent/Legal Guardian



