MANTACHIE RURAL HEALTH CARE, INC.

PATIENT REGISTRATION

In order to provide continuity of care, please select a provider:

☐ Robert Dale, Jr., MD ☐ Donna Cannon, CFNP ☐ Amanda Martin, CFNP ☐ Claire Wright, CFNP

PATIENT _____
LAST NAME FIRST NAME MIDDLE INITIAL

ADDRESS _____
STREET/P.O. BOX CITY STATE ZIP COUNTY

PRIMARY PHONE NUMBER _____ Social Security # _____

Gender: ☐ Male ☐ Female DATE OF BIRTH _____ E-MAIL _____

RACE: (check all that apply) ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American
☐ White ☐ Hispanic or Latino ☐ American Indian/Alaska Native ☐ More than one race

ETHNICITY: Are you of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, or a Hispanic/Latino born in the U.S.A.? ☐ **YES** ☐ **NO**

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

ARE YOU EMPLOYED? ____ **EMPLOYER'S NAME** _____ **PHONE #** _____

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED?

Contact Name _____ Phone _____ Relationship _____

Contact Name _____ Phone _____ Relationship _____

DO YOU HAVE MEDICAL INSURANCE? ☐ **YES** ☐ **NO** If yes, Primary Insurer _____

Contract # _____ Group # _____ Subscriber # _____

Medicare # _____ ☐ Part B ☐ Part D Medicaid # _____

RESPONSIBLE PARTY (IF MINOR/ DEPENDENT) _____

Address of responsible party (if different) _____

Spouse (or responsible party) Social Security # _____ Phone: _____

ESTIMATED YEARLY FAMILY INCOME _____ ***TOTAL NUMBER OF PERSONS IN THE FAMILY*** _____

- **Do you have an advance directive or Living Will?** ☐ Yes ☐ No
- **Do you have a Medical Power of Attorney?** ☐ Yes ☐ No
- **Are you a Veteran?** ☐ Yes ☐ No
- **Do you consider yourself homeless?** ☐ Yes ☐ No
- **Do you reside in Public House (Section 8?)** ☐ Yes ☐ No

PREFERRED LANGUAGE? ( ) English ( ) Spanish Special communication needs?

Preferred method of communication: Phone _____ Email _____ Patient Portal _____ Unspecified _____

TO BE READ AND SIGNED BY PATIENTS WITH INSURANCE, MEDICAID, AND/OR MEDICARE:
I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE SUCH INFORMATION TO THE Social Security Administration, the Medicaid Commission, the Centers for Medicare and Medicaid, or any other third party payor, or their intermediaries or carriers, needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical claims be made to this clinic.

_____ _____
ASSIGNMENT/AUTHORIZATION SIGNATURE DATE

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance that my insurance does not cover. I agree to ACCEPT COMPLETE RESONSIBILITY for all charges based on ability to pay. In the event of default, I agree to pay all costs of collection, including reasonable attorney fees. I also authorize Mantachie Rural Health Care, Inc. and my insurance to release any information required to process my claims. I give permission for any medical treatment, including but not limited to examination, injections an minor medical procedures as may be ordained advisable or necessary by the clinical staff of Mantachie Rural Health Care, Inc.

_____ _____
Patient/ Guardian Signature Date

Updated 6/2017 jj

Mantachie Rural Health Care, Inc. – 5681 HWY 363, Mantachie, MS, 38855

MEDICAL HISTORY

Date of Birth _____ Name _____ Date _____

The information that you will provide on this form will be added to your electronic medical record.

PAST MEDICAL HISTORY: Have you ever been diagnosed with one or more of the following conditions?

☐ Anemia	☐ Goiter	☐ Mental Disorders
☐ Asthma	☐ Heart Disease	☐ Migraines
☐ Bleeding Disorders	☐ Hepatitis	☐ Seizures
☐ Cancer	☐ High Blood Pressure	☐ Stomach Ulcers
☐ Colitis	☐ Kidney Disease	☐ Stroke
☐ Diabetes	☐ Lung Disease	☐ Tuberculosis
☐ Drug or Alcohol Abuse	☐ Lupus	☐ Other _____

LIST ANY SURGERIES, INCLUDING THE YEAR OF THE SURGERY:

_____

_____

_____

FAMILY HISTORY: Circle who in your family had such condition (if any)

Migraine	FATHER	MOTHER	SIBLING	GRANDFATHER	GRANDMOTHER
Anxiety	FATHER	MOTHER	SIBLING	GRANDFATHER	GRANDMOTHER
Arthritis	FATHER	MOTHER	SIBLING	GRANDFATHER	GRANDMOTHER
Heart	FATHER	MOTHER	SIBLING	GRANDFATHER	GRANDMOTHER
Hypertension	FATHER	MOTHER	SIBLING	GRANDFATHER	GRANDMOTHER
Glaucoma	FATHER	MOTHER	SIBLING	GRANDFATHER	GRANDMOTHER
Stroke	FATHER	MOTHER	SIBLING	GRANDFATHER	GRANDMOTHER
Asthma	FATHER	MOTHER	SIBLING	GRANDFATHER	GRANDMOTHER
Thyroid	FATHER	MOTHER	SIBLING	GRANDFATHER	GRANDMOTHER
Cancer (Type?) _____	FATHER	MOTHER	SIBLING	GRANDFATHER	GRANDMOTHER
Mental Illness	FATHER	MOTHER	SIBLING	GRANDFATHER	GRANDMOTHER
State Hospital	FATHER	MOTHER	SIBLING	GRANDFATHER	GRANDMOTHER
Suicide	FATHER	MOTHER	SIBLING	GRANDFATHER	GRANDMOTHER
Depression	FATHER	MOTHER	SIBLING	GRANDFATHER	GRANDMOTHER
Bipolar	FATHER	MOTHER	SIBLING	GRANDFATHER	GRANDMOTHER
Diabetes	FATHER	MOTHER	SIBLING	GRANDFATHER	GRANDMOTHER
Other_____	FATHER	MOTHER	SIBLING	GRANDFATHER	GRANDMOTHER

 # OF SIBILINGS Male _____ Female _____ **# OF CHILDREN Male _____ Female _____**

Are you currently receiving:

☐ HOME HEALTH ☐ HOSPICE ☐ PHYSICAL THERAPY ☐ HOUSEKEEPING SERVICES ☐ RESPIRATORY SERVICES.

5/2015 jj

Date of Birth _____ Name _____ Date _____

SOCIAL HISTORY: (Circle what applies to you)

Do you use tobacco? Yes No If yes, how many a day?_____

Have you had alcohol in the past year? Yes No If yes, how many drinks a day?_____

Do you use recreational drugs? Yes No If yes, please list_____

Are you sexually active? Yes No

Do you drink caffeine? Yes No If yes, how much per day? _____

Are you married? Yes No

Does your home have: _____ pets _____ smoke detector _____ smoke alarm _____ fire extinguisher?

Do you have any **drug, food or environmental allergies** (like pollens, dust mites, chemicals, etc.)? Yes No

If yes, please **list** and write **the reaction you had**.

ALLERGIC TO:	**TYPE OF REACTION:**

MEDICATIONS, including all over the counter medications and dietary supplements:

NAME OF MEDICATION	**STRENGTH**	**HOW OFTEN DO YOU TAKE THIS MEDICATION**

PREFERRED PHARMACY_____ **Phone** _____

ALTERNATE PHARMACY_____ **Phone** _____

NAME_____**DOB**_____**DATE**_____

I give permission to release the following information t the people listed below:

___ ALL
___ TEST RESULTS (ekg, xray, bloodwork , etc.)
___ APPOINTMENTS/REFERRALS
___ MEDICAL CONDITIONS
___ MEDICATIONS
___ OTHER. (Please specify_____

NAME	RELATIONSHIP	PHONE#

I, hereby, authorize the above people to have access to my medical records.

NOTICE OF PRIVACY PRACTICE RECEIPT

I_____, **have received a copy of the Notice of Privacy Practice of Mantachie Rural Health Care, Inc. and all my questions about it have been answered.**

_____ _____
Signature **Date**

_____ _____
Parent/ Guardian Signature **Date**

PATIENT'S NAME: _____ DATE OF BIRTH: _____

MANTACHIE RURAL HEALTH CARE, INC.

Quality Primary Health Care is a priority at our federally funded Community Health Center. Please help us capture data relating to Race, Ethnicity, Language Needed, Sexual Orientation/Gender Identity so that we may better serve our patient population and improve overall health outcomes.

Do you consider yourself of Hispanic or Latino Ethnicity? ( ) Yes ( ) No

Please indicate your Race:

- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ More than one race
- ☐ Refuse to report

Please indicate the best language to use for your understanding:

- ☐ English
- ☐ Other: _____

Please check your Sexual Orientation and Gender Identify:

Please check one	SEXUAL ORIENTATION	Please check one	GENDER IDENTIFY
	Choose Not to Disclose		Choose Not to Disclose
	Straight (not lesbian or gay)		Male
	Lesbian or Gay		Female
	Bisexual		Transgender – Male: Female-to-Male
	Something Else		Transgender – Female: Male-to-Female
	Don't Know		Other

_____ _____

Signature of Patient or Parent/Guardian **Date**

MANTACHIE RURAL HEALTHCARE, INC
PO BOX 40
MANTACHIE, MS 38855

PHONE-662-282-4226 **FAX-662-282-7946**

Date_____

I hereby authorize you to release my records

From

_____

To: Mantachie Rural Health Care, Inc.

Any information including the diagnosis and records of any treatment or examination rendered to during the period _____ to _____. (Including lab and x-rays)

Name_____

Date of birth _____

Social Security #_____

Signature_____

Witness_____

_____