Mantachie
Rural Health Care, Inc.

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

☐ Robert Dale, Jr., MD ☐ Donna Cannon, CFNP ☐Amanda Martin, CFNP ☐Crystal Nichols, CFNP

PATIENT: _____
LAST NAME FIRST NAME MIDDLE NAME

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

PHONE NUMBER: _____ **SOCIAL SECURITY #**: _____

GENDER: ☐ Male ☐ Female **DATE OF BIRTH:** _____ **E-MAIL:** _____

RACE:(check all that apply) ☐Asian ☐ Black/African American ☐Other Pacific Islander ☐Native Hawaiian ☐White ☐American Indian/Alaska Native ☐More than one race ☐Choose Not to Disclose

ETHNICITY: Do you consider yourself of Hispanic or Latino Ethnicity? ☐Yes ☐ No

SEXUAL ORIENTATION:

- ☐Choose Not to Disclose
- ☐Straight (Not Lesbian or Gay)
- ☐Lesbian or Gay
- ☐Bisexual
- ☐Something Else
- ☐Don't Know

GENDER IDENTITY:

- ☐Choose Not to Disclose
- ☐Male
- ☐Female
- ☐Transgender – Male: Female-to-Male
- ☐Transgender – Female: Male-to-Female
- ☐Other

MARITAL STATUS: ☐Single ☐Married ☐Widowed ☐Divorced

ARE YOU EMPLOYED? ☐Yes ☐No

EMPLOYER'S NAME: _____ **PHONE #:** _____

DO YOU HAVE MEDICAL INSURANCE? ☐Yes ☐No If yes, Primary Insurer _____

Contract # _____ Group # _____ Subscriber # _____

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

ESTIMATED YEARLY FAMILY INCOME $_____ **TOTAL NUMBER OF PEOPLE IN 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 ☐ Other: _____

SPECIAL COMMUNICATION NEEDS? ☐ Yes ☐ No

PREFERRED METHOD OF COMMUNICATION: ☐ Phone ☐E-mail ☐Patient Portal

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 and minor medical procedures as may be ordained advisable or necessary by the clinical staff of Mantachie Rural Health Care, Inc.

_____ _____
PATIENT / GUARDIAN SIGNATURE DATE

PRIVACY RELEASE

_____	_____	_____
DATE OF BIRTH	**NAME**	**DATE**

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

NAME	**RELATIONSHIP**	**PHONE #**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED?

Contact Name _____ Phone _____ Relationship _____

Contact Name _____ Phone _____ Relationship _____

RESPONSIBLE PARTY (IF MINOR / DEPENDENT) _____

Address of responsible party (if different) _____

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

NOTICE OF PRIVACY PRACTICE RECEIPT

I have received a copy of the Notice of Privacy Practice of Mantachie Rural Health Care, Inc. and any related questions have been answered.

_____	_____
Patient / Guardian Signature	Date

MEDICAL HISTORY

_____ _____ _____

DATE OF BIRTH **NAME** **DATE**

PAST MEDICAL AND FAMILY HISTORY: Please check if anyone diagnosed with the following conditions

	Anemia	Asthma	Cancer	COPD	Diabetes	Emphysema	Heart Disease	Hepatitis	High Blood Pressure	Kidney Disease	Lupus	Mental Disorders	Migraines	Seizures	Stomach Ulcers	Stroke	Substance Abuse	Tuberculosis	Other
Self																			
Father																			
Mother																			
Paternal Grandfather																			
Paternal Grandmother																			
Maternal Grandfather																			
Maternal Grandmother																			

NUMBER OF SIBILINGS Male: _____ Female: _____ **NUMBER OF CHILDREN** Male: _____ Female: _____

LIST ANY SURGERIES, INCLUDING THE YEAR OF THE SURGERY:

_____

_____

_____

SOCIAL HISTORY:

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 use protection? ☐ Yes ☐ No

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** _____

Mantachie
Rural Health Care, Inc.
P.O. BOX 40 – 5681 HWY. 363
MANTACHIE, MS 38855

PHONE (662) 282-4226
FAX (662) 282-4287
www.mantachieclinic.org

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 me during the

period of _____ **to** _____ **(including labs and x-rays).**

_____ **most recent PAP** _____ **most recent mammogram**

NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

SIGNATURE: _____

WITNESS: _____