MANTACHIE RURAL HEALTHCARE, INC
BEHAVIORAL HEALTH
PATIENT REGISTRATION

Timothy Gillespie, LCSW **Debbie Pannell, LCSW** **Elizabeth Duncan, PMHNP-BC**

PATIENT _____
FIRST NAME MIDDLE INITIAL LAST NAME

ADDRESS_____
STREET/P.O. BOX CITY STATE ZIP COUNTY

PRIMARY PHONE NUMBER_____ **Social Security #**_____

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

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced

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**

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

EMPLOYED FULL TIME: ☐ **PART TIME:** ☐ **DISABLED:** ☐

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED?
Contact Name_____ Phone _____ Relationship _____

DO YOU HAVE MEDICAL INSURANCE? ☐ **YES** ☐ **NO** If yes, Primary Insurer_____
Contact # _____ Group # _____ Subscriber # _____
Medicare # _____ ☐ Part B ☐ Part D Medicaid # _____

RESPONSIBLE PARTY (IF MINOR/ DEPENDENT) _____
Social Security # _____ Date of Birth: _____
Address: _____ Phone: _____

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

- **Is the patient a Veteran?** ☐ **Yes** ☐ **No**
- **Does the patient have vision barriers?** ☐ **Yes** ☐ **No**
- **Does the patient have hearing barriers?** ☐ **Yes** ☐ **No**
- **Is the patient considered homeless?** ☐ **Yes** ☐ **No**
- **Do you reside in Public House (Section 8?)** ☐ **Yes** ☐ **No**

PREFERRED LANGUAGE? English ☐ Spanish ☐ Special communication needs? ☐ YES ☐ NO
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 RESPONSIBILITY 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

Mantachie
Rural Health Care, Inc.

Notice of Random Drug Screening Policy

As per clinical policy of Mantachie Behavioral Health Clinic I, _____ understand I may be asked to submit a urine sample for random urine drug screening at or during any visit. I also understand that a clinical staff member of Mantachie Rural Health Care will directly observe the urine collection procedure. I also understand that I will not be allowed to leave the premises and return at a later time, and that drug screens are random and requested at the NP/Physician's discretion.

☐ I agree to submit a urine sample for urine drug screening and understand the procedure.

☐ I **do not** agree to the above and understand I may not be seen today in this clinic nor will I receive any prescriptions.

_____

Patient Signature Date

_____

Witness Signature

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

PATIENT'S NAME: _____ DATE OF BIRTH: Yhhh

MANTACHIE RURAL BEHAVIORAL 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

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Please indicate your Race:

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

Please indicate the best language to use for your understanding:

☐ English
☐ Other:

Please check your Sexual Orientation and Gender Identify:

Check One	Sexual Orientation	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

Pharmacy: _____ **Pharmacy Phone Number:** _____

Mantachie Behavior Health Clinic, INC
5510 HWY 363
Mantachie, MS 38855
Phone: 662-282-4359
Fax: 662-282-7040

Date: _____

I hereby authorize you to release my records

From: _____

To: Mantachie Behavior Health Clinic, INC

Any information including diagnosis, medication history, medication administration, psychological evaluation (Including notes & history), treatments, and examinations (including labs & x-rays) during the period _____ to _____.

Name: _____

DOB: _____ SS#: _____

Signature: _____

Witness: _____

CONFIDENTIALITY AND PRIVACY NOTICE

Mantachie Behavioral Health – 5510 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
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Colitis
- ☐ Diabetes
- ☐ Drug or Alcohol Abuse
- ☐ Goiter
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Mental Disorders
- ☐ Migraines
- ☐ Seizures
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ 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?) 6_____	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.

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** Jk_____

ALTERNATE PHARMACY_____ **Phone** _____