



HOMETOWN CARE OF NORTH MS

Ph. 662-276-5065 Fax: 866-554-1320

220 W. Main St.

Okolona, MS 38860

PATIENT REGISTRATION

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 _____

Contract # _____ 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



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email: htcnms@gmail.com

Notice of Random Drug Screening Policy

As per clinical policy of HOMETOWN CARE OF NORTH MS 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 HOMETOWN CARE OF NORTH MS 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 #

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: _____

HOMETOWN CARE OF NORTH MS

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:

- | | |
|---|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Black/African American |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Other Pacific Islander | <input type="checkbox"/> American Indian/Alaska Native |
| <input type="checkbox"/> More than one race | <input type="checkbox"/> 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
<input type="checkbox"/>	Choose Not to Disclose	<input type="checkbox"/>	Choose Not to Disclose
<input type="checkbox"/>	Straight (Not lesbian or gay)	<input type="checkbox"/>	Male
<input type="checkbox"/>	Lesbian or Gay	<input type="checkbox"/>	Female
<input type="checkbox"/>	Bisexual	<input type="checkbox"/>	Transgender - Male: Female-to-Male
<input type="checkbox"/>	Something Else	<input type="checkbox"/>	Transgender- Female: Male-to-Female
<input type="checkbox"/>	Don't Know	<input type="checkbox"/>	Other

Signature of Patient or Parent/Guardian

Date

Pharmacy: _____ Pharmacy Phone Number: _____



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Date: _____

I hereby authorize you to release my records

From: _____

To: HOMETOWN CARE OF NORTH MS

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

The information contained in this message, and attachments hereto, is confidential, and it may contain Protected Health information that is subject to use and disclosure restrictions under federal law. It is intended only for the use of the individual of entity named above. If the recipient or reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this message is strictly prohibited. If you have received this message in error, please notify us immediately so that we can arrange for the return of the original materials. All recipients are expected to maintain appropriate protections on the information contained herein.



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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?

- | | | |
|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Drug or Alcohol Abuse | <input type="checkbox"/> Lupus | <input type="checkbox"/> Other _____ |

LIST ANY SURGERIES, INCLUDING THE YEAR OF THE SURGERY:

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

Migraine	FATHER <input type="checkbox"/>	MOTHER <input type="checkbox"/>	SIBLING <input type="checkbox"/>	GRANDFATHER <input type="checkbox"/>	GRANDMOTHER <input type="checkbox"/>
Anxiety	FATHER <input type="checkbox"/>	MOTHER <input type="checkbox"/>	SIBLING <input type="checkbox"/>	GRANDFATHER <input type="checkbox"/>	GRANDMOTHER <input type="checkbox"/>
Arthritis	FATHER <input type="checkbox"/>	MOTHER <input type="checkbox"/>	SIBLING <input type="checkbox"/>	GRANDFATHER <input type="checkbox"/>	GRANDMOTHER <input type="checkbox"/>
Heart	FATHER <input type="checkbox"/>	MOTHER <input type="checkbox"/>	SIBLING <input type="checkbox"/>	GRANDFATHER <input type="checkbox"/>	GRANDMOTHER <input type="checkbox"/>
Hypertension	FATHER <input type="checkbox"/>	MOTHER <input type="checkbox"/>	SIBLING <input type="checkbox"/>	GRANDFATHER <input type="checkbox"/>	GRANDMOTHER <input type="checkbox"/>
Glaucoma	FATHER <input type="checkbox"/>	MOTHER <input type="checkbox"/>	SIBLING <input type="checkbox"/>	GRANDFATHER <input type="checkbox"/>	GRANDMOTHER <input type="checkbox"/>
Stroke	FATHER <input type="checkbox"/>	MOTHER <input type="checkbox"/>	SIBLING <input type="checkbox"/>	GRANDFATHER <input type="checkbox"/>	GRANDMOTHER <input type="checkbox"/>
Asthma	FATHER <input type="checkbox"/>	MOTHER <input type="checkbox"/>	SIBLING <input type="checkbox"/>	GRANDFATHER <input type="checkbox"/>	GRANDMOTHER <input type="checkbox"/>
Thyroid	FATHER <input type="checkbox"/>	MOTHER <input type="checkbox"/>	SIBLING <input type="checkbox"/>	GRANDFATHER <input type="checkbox"/>	GRANDMOTHER <input type="checkbox"/>
Cancer (Type?) 6 _____	FATHER <input type="checkbox"/>	MOTHER <input type="checkbox"/>	SIBLING <input type="checkbox"/>	GRANDFATHER <input type="checkbox"/>	GRANDMOTHER <input type="checkbox"/>
Mental Illness	FATHER <input type="checkbox"/>	MOTHER <input type="checkbox"/>	SIBLING <input type="checkbox"/>	GRANDFATHER <input type="checkbox"/>	GRANDMOTHER <input type="checkbox"/>
State Hospital	FATHER <input type="checkbox"/>	MOTHER <input type="checkbox"/>	SIBLING <input type="checkbox"/>	GRANDFATHER <input type="checkbox"/>	GRANDMOTHER <input type="checkbox"/>
Suicide	FATHER <input type="checkbox"/>	MOTHER <input type="checkbox"/>	SIBLING <input type="checkbox"/>	GRANDFATHER <input type="checkbox"/>	GRANDMOTHER <input type="checkbox"/>
Depression	FATHER <input type="checkbox"/>	MOTHER <input type="checkbox"/>	SIBLING <input type="checkbox"/>	GRANDFATHER <input type="checkbox"/>	GRANDMOTHER <input type="checkbox"/>
Bipolar	FATHER <input type="checkbox"/>	MOTHER <input type="checkbox"/>	SIBLING <input type="checkbox"/>	GRANDFATHER <input type="checkbox"/>	GRANDMOTHER <input type="checkbox"/>
Diabetes	FATHER <input type="checkbox"/>	MOTHER <input type="checkbox"/>	SIBLING <input type="checkbox"/>	GRANDFATHER <input type="checkbox"/>	GRANDMOTHER <input type="checkbox"/>
Other _____	FATHER <input type="checkbox"/>	MOTHER <input type="checkbox"/>	SIBLING <input type="checkbox"/>	GRANDFATHER <input type="checkbox"/>	GRANDMOTHER <input type="checkbox"/>

OF SIBILINGS Male _____ Female _____

OF CHILDREN Male _____ Female _____

Are you currently receiving:

- HOME HEALTH HOSPICE PHYSICAL THERAPY HOUSEKEEPING SERVICES RESPIRATORY SERVICES.



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_____ 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** _____