HOMETOWN CARE OF NORTH MS
Ph. 662-276-5065 Fax: 866-554-1320
220 W. Main St.
Okolona, MS 38860

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: _____

PREFERRED PHARMACY _____

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

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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** _____

Patient Name_____

BRIEF Health Literacy Screening Tool (BRIEF)

Please circle the answer that best represents your response.

1. How often do you have someone help you read hospital materials?
   - ◯1. Always
   - ◯2. Often
   - ◯3. Sometimes
   - ◯4. Occasionally
   - ◯5. Never

2. How often do you have problems learning about your medical condition because of difficulty understanding written information?
   - ◯1. Always
   - ◯2. Often
   - ◯3. Sometimes
   - ◯4. Occasionally
   - ◯5. Never

3. How often do you have a problem understanding what is told to you about your medical condition?
   - ◯1. Always
   - ◯2. Often
   - ◯3. Sometimes
   - ◯4. Occasionally
   - ◯5. Never

4. How confident are you filling out medical forms by yourself?
   - ◯1. Not at all
   - ◯2. A little bit
   - ◯3. Somewhat
   - ◯4. Quite a bit
   - ◯5. Extremely

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0 ○	1 ○	2 ○	3 ○
2. Feeling down, depressed, or hopeless	0 ○	1 ○	2 ○	3 ○
3. Trouble falling or staying asleep, or sleeping too much	0 ○	1 ○	2 ○	3 ○
4. Feeling tired or having little energy	0 ○	1 ○	2 ○	3 ○
5. Poor appetite or overeating	0 ○	1 ○	2 ○	3 ○
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0 ○	1 ○	2 ○	3 ○
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ○	1 ○	2 ○	3 ○
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0 ○	1 ○	2 ○	3 ○
9. Thoughts that you would be better off dead, or of hurting yourself	0 ○	1 ○	2 ○	3 ○
	add columns		+	+
	TOTAL:			

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all ○
- Somewhat difficult ○
- Very difficult ○
- Extremely difficult ○

A2663B 10-04-2005

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DATE: _____

I hereby authorize you to release my records

FROM: _____

TO:

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: _____