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 _____
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 HOMETOWN CARE OF NORTH MS 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 HOMETOWN CARE OF NORTH MS.

_____ _____
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 **HOMETOWN CARE OF NORTH MS** and any related questions have been answered.

_____ _____

Patient / Guardian Signature Date

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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

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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?

- ☐ 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.

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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** _____

5/2015 jj