Minidoka Medical Center

RHC

1308 8th St Ste 1

Rupert, ID 83350

(P) 1-208-436-4322 (F) 1-208-436-1312

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information.

Please print. All information will be confidential.

# **Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Last MI First**

Male \_\_\_\_\_ Female \_\_\_\_\_ SSN(required)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**Physical Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_**

**Mailing Address (if different)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_ Zip\_\_\_\_\_\_**

**Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Portal Yes□ No□**

## We will not use your email for solicitation. It is for communication purpose via portal only.

## Marital Status: Married \_ Single\_ Divorced\_ Separated \_ Widowed\_ Widowed/remarried\_ Significant other\_

## Patients or Parents Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## If minor child list name of parent/head of household \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Parent/guarantor date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone number if different\_\_\_\_\_\_\_\_\_\_

### Person to contact in case of emergency? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth-date of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# **Relationship to pt.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**SSN of insured:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **ID Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Group #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **Amount of deductible** $\_\_\_\_\_\_\_\_\_ **or Co-Pay** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to pt. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth-date of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **Relationship to pt.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**SSN of insured:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **ID Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Group #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **Amount of deductible** $\_\_\_\_\_\_\_\_\_ **or Co-Pay** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **I understand that I am financially responsible for the payment of medical charges incurred on my behalf at, Minidoka Medical Center, regardless of third party coverage. I consent to and authorize Minidoka Medical Center to furnish medical information to any third party who may be responsible for payment of all or part of my charges incurred at Minidoka Medical Center. I authorize my insurance company, or any responsible third party to pay benefits directly to Minidoka Medical Center.**

# **Minidoka Medical Center RHC, under direction of Minidoka Memorial Hospital does not carry self-pay balances beyond 90 days of date of service.**

# **X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### Signature of patient or parent if minor

MINIDOKA MEDICAL CENTER RHC

1308 8th St. Ste 1 Rupert, ID 83350 (p) 436-4322 (f) 208-436-1312

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent for Photograph

I consent to allow photography of myself for identification purposes and for purposes of improving my medical care documentation (ie: wounds, lesions, etc)..

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGN HERE

AUTHORIZATION FOR TREATMENT

I hereby authorize, Minidoka Medical Center, and any assistants or associates that may be designated, to perform medical and hospital care to the above named patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sign here Date

Privacy Practices

I have received/or declined copy of the Notice Of Privacy Practices and I have been provided an opportunity to review this entire document

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGN HERE

Consent to use of answering machine and/or voicemail messaging/email:I hereby consent to the use of my answering machine and/or voicemail for the purpose of relaying important information regarding my treatment or care, including, but no limited to confirmation of appointments, changes in medication, results of lab tests, special instructions for testing procedures. I also consent to members of my family receiving this information in my absence. This consent will remain in effect until I rescind the consent in writing.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Patient representative Date

Persons who can call and receive your medical information:

Name Relationship Phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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FOR MEDICARE PATIENTS: Medicare Authorization to receive payments:

Medicare Identification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request that payment of authorized Medicare benefits be made either to me, or on my behalf to Minidoka Medical Center/Rural Health Clinic for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formally the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUPPLEMENTAL AUTHORIZATION TO RECEIVE PAYMENTS

*Sign ONLY if you have a Medicare secondary insurance)*

PATIENT MEDICARE Identification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Supplemental Insurance Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUPPLEMENTAL INSURANCE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUPPLEMENTAL INSURANCE POLICY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I request that payment of authorized Medicare benefits be made on my behalf to Minidoka Medical Center/Rural Health Clinic for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to Minidoka Medical Center any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History**

**This is confidential information and will be used only for the purpose of your healthcare.**

 ***Allergies to medications? None □ What happens?***

|  |  |
| --- | --- |
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 ***Medications None □***

***Name of Medication Strength How many times a day do you take it?***

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 **Please attach another paper if needed**

***Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Medical History:**

|  |  |  |
| --- | --- | --- |
| **Please describe any problems****you have ever had with any of the listed topics:** | USE THIS COLUMN TO DESCRIBE DETAILS OF***YOUR*** Current and Past Medical History | USE THIS COLUMN TO DESCRIBE DETAILS OF**FAMILY**Medical history (Father/Mother/Siblings/Grandparents, etc)  |
| SKIN, HAIR, NAILS, TEETHDo you wear dentures? Y N |  |  |
| EYES, EARS, NOSE, THROATGlasses Y N Hearing aid Y N |  |  |
| HEART PROBLEMS?Have you had a heart attack? Y NDo you have high cholesterol? Y N High blood pressure? Y N |  | Has anyone in your family had a heart attack? Y N |
| LUNGS/BREATHING PROBLEMS? Y N |  |  |
| STOMACH PROBLEMS? Y N |  |  |
| LIVER / PANCREAS PROBLEMS? Y N |  |  |
| BOWEL PROBLEMS? Y N |  |  |
| KIDNEY PROBLEMS? Y N |  |  |
| ARTHRITIS/JOINT PROBLEMS?  Y N  |  |  |
| WEAKNESS? Y N |  |  |
| Have you ever had a stroke? Y NHave you ever had seizures? Y N |  |  |
| ANEMIA / BLEEDING PROBLEMS? Y N |  |  |
| CANCER? Y N ( Type) |  |  |
| DIABETES? Y N If so, for how long?\_\_\_\_\_\_Pills or Insulin  |  |  |
| THYROID PROBLEMS? Y N |  |  |
| *Women*: How many pregnancies?\_\_ How many deliveries?\_\_\_Number of Miscarriages?\_\_\_When was your last menstrual period?\_\_\_\_\_\_\_\_\_\_Have you had a hysterectomy? Y N |  |  |
| Have you ever suffered from depression? Y NHave you every suffered from anxiety? Y NOther problems? |  |  |
| Previous Doctors and hospitals that have provided medical care for you:Please list name of Doctor and city/state where they are located: |  |  |

***Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Please list previous hospitalizations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Family History:* Father: Living □ Deceased □ How old when he passed away and why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mother: Living □ Deceased □ How old when she passed away and why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Number of Brother(s): \_\_\_\_\_\_ Health Problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Number of Sister(s): \_\_\_\_\_\_ Health Problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Preventative (have you ever had any of these tests, and when was the testing done***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Colonoscopy** | **Bone Density** | **Mammo** | **PAP** | **PSA** | **Eye Exam** | **Foot Exam****(If diabetic)** | **Rectal Exam**  |
| **Date**  |  |  |  |  |  |  |  |  |
| **Normal** |  |  |  |  |  |  |  |  |
| **Abnormal** |  |  |  |  |  |  |  |  |
| **Due Date** |  |  |  |  |  |  |  |  |
| **Where ?** |  |  |  |  |  |  |  |  |

***Surgical History and Dates:*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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***Occupation:***Employed □ Unemployed □ Retired □ Homemaker □ Disabled □ Student □

If employed what is your type of work?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you sexually Active? Yes □ No □ Multiple Partners □ Birth control □ Condoms □ Other\_\_\_\_\_\_\_\_\_\_\_

Number of children \_\_\_\_\_\_ Number who are male\_\_\_\_\_\_\_ Number who are female\_\_\_\_\_\_

***Activity Status:*** Athletic □ Active/Fit □ Occasionally/Rarely □ Never □ Ideal body weight for you\_\_\_\_\_\_

***Tobacco Products/Nicotine:*** Cigarettes □ Cigars □ Smokeless/Chew □ E-cigarette/ Vape □ None□ Currently use□ How many per day\_\_\_\_\_\_ How many years smoked\_\_\_\_\_\_\_ Quit□ Quit Date\_\_\_\_\_\_\_\_

***Alcohol Use:*** Daily □ Weekly □ Socially □ Rarely □ Beer □ Wine □ Hard Alcohol □ None □

***Caffeinated Products:*** Coffee□ # /day\_\_\_\_ Tea□ #/day\_\_\_\_ Soda Pop□ #/day\_\_\_\_ Energy Drink□ #/day\_\_\_\_

***Illegal Drugs:*** Marijuana□ Methamphetamines □ Cocaine□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ None□

Experimented with □ Currently Use □ Quit □ When did you quit\_\_\_\_\_\_\_\_ Rehabilitation □ Self Recovery □

***Mental Health:* N/A□** Depression □ Anger Problems □ Bipolar □ Cutting □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Not treated □ Treated □ If treated, Dr. name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Communicable Diseases:* NA□** Measles □ Mumps □ HIV/AIDS □ Hepatitis □ A □ B□ C□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Code Status:* Full Code**- all lifesaving measures □ **DNR**-Do not resuscitates □

**I would like to talk to the doctor about this**  □

***Which pharmacy do you use?***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Patient Signature***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Date***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_