Minidoka Medical Center/ RHC

1308 8th Street, suite 1 Rupert, ID 83350 (208) 436-4322 Fax (208)436-1312

Adult Patient Demographics

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 _____
First MI Last

Date of Birth____/____/_____ SSN_____ Male ____ Female ____

Physical _____ _____ _____ _____

Address City State Zip Mailing Address City State Zip

_____ _____ _____ _____

Home Phone cell Phone

_____ _____

Email address

_____

Will you use Patient Portal for communication with your doctor Yeso Noo Marital Status:

Married o Singlen Divorced o Separated o Widowed o Widowed but remarried o Significant Other o

Parent/guarantor date of birth: Phone number if different

_____ _____

Patient's Employer Work Phone

_____ _____

Person to contact in case of emergency? mergency? _____ Phone _____

Relationship to patient:_____

Person who can call and receive patient medical information: (for confidentiality purposes)

Name: Relationship: Phone:

_____ _____ _____

_____ _____ _____

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 {f

Amount of deductible $ or Co-Pay

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. xDate

Name' DOB Today's Date

ASSIGNMENT AND RELEASE

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 ay responsible third party to pay benefits directly to Minidoka Medical Center.

Initial Here

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).

Initial 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

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

FOR MEDICARE PATIENTS: Medicare Authorization to receive a ments:

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 ifyou 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 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 Minidoka Medical Center Any information needed to determine these benefits or the benefits payable for related services.

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SIGNATURE DATE

Health History

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

Name DOB
Today's Date

Allergies to medications? None o What happens?

Medications None o

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

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 Histo	USE THIS COLUMN TO DESCRIBE DETAILS OF FAMILY Medical history Father/Mother/Siblin s/Grand arents, etc
SKIN, HAIR, NAILS, TEETH Do ou wear dentures? Y N		
EYES, EARS, NOSE, THROAT Glasses Y N Hearin aid Y N		
HEART PROBLEMS? Have you had a heart attack? Y N Do you have high cholesterol? Y N Hi h blood ressure? Y N		Has anyone in your family had a heart attack? Y
LUNGS/BREATHING PROBLEMS? Y N		

STOMACH PROBLEMS? Y N		
LIVER / PANCREAS PROBLEMS? Y N		
BOWEL PROBLEMS? Y		
KIDNEY PROBLEMS? Y N		
ARTHRITIS/JOINT PROBLEMS?		
WEAKNESS?		
Have you ever had a stroke? Y N Have ou ever had seizures? Y N		
ANEMIA / BLEEDING PROBLEMS?		
CANCER? Y N T e)		
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 N Have you every suffered from anxiety? Y N Other 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 o Deceased o How old when he passed away and why?_____

Mother: Living o Deceased o How old when she passed away and why?_____

Number of Brother(s): Health Problems:_____

Number ofSister(s): Health Problems:_____

Preventative (have you ever had anv of these tests, and when was the testinq done

	Colonoscopy	Bone Density	Mammo	PAP	PSA	Eye Exam	Foot Exam diabetic)	Rectal Exam
Date								
Normal								
Abnormal								
Due Date								
Where ?								

Surgical History and Dates:

_____

_____

_____

Occupation:Employed o Unemployed o Retired o Homemaker o Disabled o Student o If employed what is your type of work?_____

Are you sexually Active? Yes o Noo Multiple Partners Birth control o Condoms o Other_____
Number of children Number who are male Number who are female_____

Activitv Status: Athletic o Active/Fito Occasionally/Rarelyo Never o Ideal body weight for you_____

Tobacco Products/Nicotine: Cigarettes o Cigars o Smokeless/Chew o E-cigarette/ Vape o Noneo
Currently usea How many per day_____ How many years smoked_____ Quito Quit Date_____

Alcohol Use: Daily Weekly o Socially o Rarely o Beer o Wine o Hard Alcoholo None o

Caffeinated Products: Coffeeo # /day Tean #/day Soda Popo it/day Energy Drinko it/day_____

Illeqal Druqs: Marijuanao Methamphetamines o Cocaineo Other_____ Noneo
Experimented with o Currently Usea Quit o When did you quit_____ Rehabilitation o Self Recovery o

Mental Health: N/Ao Depression o Anger Problems o Bipolar o Cutting o Other_____
Not treated o Treated o If treated, Dr. name_____

Communicable Diseases: NAO Measles o Mumps o HIV/AIDS o Hepatitis o A o Bo Co
Other_____

Code Status: Full Code- all lifesaving measures o DNR-Do not resuscitates o I would like to talk to the doctor about this o

Which pharmacv do vou use?_____

Patient Signature_____ Date_____