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
_______________________________________	___________________________________	______________________
_______________________________________	___________________________________	______________________
_______________________________________	___________________________________	______________________
_______________________________________	___________________________________	______________________

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______________

*Name*______________________________*DOB*____________________________*Today's Date*_________________

Health History

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

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

Allergies to medications?	What happens?

Medications ***None*** □

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 History	USE THIS COLUMN TO DESCRIBE DETAILS OF **FAMILY** Medical history (Father/Mother/Siblings/Grandparents, etc)
SKIN, HAIR, NAILS, TEETH Do you wear dentures? Y N		
EYES, EARS, NOSE, THROAT Glasses Y N Hearing aid Y N		
HEART PROBLEMS? Have you had a heart attack? Y N Do 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 N Have 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 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:		

***Please list previous hospitalizations:*____**

Name*____________________________DOB*_______________________***Today's Date*_________________

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:____

____

____

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*_________________________