



Minidoka Medical Center | RHC

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

Patient Demographics

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will remain confidential.

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Physical Address \_\_\_\_\_ Street/PO Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address(if different than physical) \_\_\_\_\_ Street/PO Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Preferred method of contact: Home phone Cell phone Text Email Mail

Email address \_\_\_\_\_ None

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 \_\_\_\_\_

If minor child list name of parent / guardian \_\_\_\_\_

Parent/guarantor date of birth \_\_\_\_\_ Phone number if different \_\_\_\_\_

Patient or Parents Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Person to contact in case of emergency? \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Contact number for emergency, different phone number than already listed please: \_\_\_\_\_

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

Table with 3 columns: Name, Relationship, Phone

Select your primary medical provider in this office

- Aaron Catmull, NP; Cameron McHan, NP; Shawna McCaffrey, NP; Brian Muir, DO; Jeff Swenson, MD; Casie Taylor, NP; Rebecca Warnick, NP

Primary Insurance Kevin Owens, MD FACP; ID Number; Group #; Name of Insured; Birth-date of Insured; Relationship to pt.; SSN of insured; Amount of deductible \$ or Co-Pay \$

ID Number; Group #; Name of Insured; Birth-date of Insured; Relationship to pt.; SSN of insured;

Secondary Insurance; Amount of deductible \$ or Co-Pay \$

I request that payment of authorized Commercial Insurance/Medicaid/Medicare/Medicare supplement 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 my insurance, or Centers for Medicare and Medicaid Services, and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE (for insurance assignment) \_\_\_\_\_ Date \_\_\_\_\_

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

**X**

**Date** \_\_\_\_\_

**Consent to Treat/Signature of patient or responsible party**

**Minidoka Medical Center | RHC**  
1308 8th St. Ste 1 | Rupert, ID 83350 P: 208- 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**

**Privacy Practices/Discrimination and Patient Rights and Responsibilities**

I have received/or declined copy of the Notice of Privacy Practices and Patient Rights and Responsibilities. I have been provided an opportunity to review this entire document. Minidoka Memorial Hospital and Medical Center will not discriminate against a patient because of race, color, national origin, religion, ability to pay, or because a patient is covered by a program such as Medicaid or Medicare. If you feel you are a victim of discrimination you have the right to file written complaint to the Compliance Officer. Forms are available in the business office.

\_\_\_\_\_  
**Sign here**

**Consent to use of answering machine, text and/or voicemail messaging/email**

I grant permission and consent to Minidoka Medical Clinic and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, whether provided by me or obtained on its own; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address or phone number associated with me, whether provided by me or obtained on its own; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I further agree to provide updated contact information in an effort to avoid unintended disclosures of my information and I accept and acknowledge that Minidoka Medical Clinic and its agents, assignees and contractors (which may include third party debt collectors for past due obligations) will treat any email address or phone number obtained as my private email or phone number that is not accessible by unauthorized third parties. I understand that these communications may result in charges to me by my mobile service provider, and are not encrypted. I understand that communication attempts will be made to my cellular phone during permitted calling hours based upon the time zone affiliated with the cellular phone number provided, unless notified otherwise. I understand that my refusal to provide the information described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

**Date:** \_\_\_\_\_

**Signature of Patient/Patient Representative**

Child's Name \_\_\_\_\_

Child's Date of Birth \_\_\_\_\_

Current Age \_\_\_\_\_

What is the child's sex? Female Male

Is your child adopted? No Yes If yes, at what age? \_\_\_\_\_

The child's parents are:

Single Married Divorced Separated but not divorced Widowed

Living together but not married

List your child's main health problems (or reasons for visiting the clinic).

Routine checkup

Immunizations (shots)

A health problem (please specify) \_\_\_\_\_

Switching doctors (last doctor) \_\_\_\_\_

How well do you feel your child acts or behaves?

Poor Fair Good Very Good Excellent

Has your child ever been a patient in a hospital (please include surgeries)?

No

Yes (If yes, explain why and when below.)

<u>My child was in the hospital because:</u>	<u>When</u>

Is your child taking any prescription medicines?

Yes - Please list the child's medicines below or I brought my child's medicines.

No. My child does not take any prescription medicines.

Name of medicine	Dosage	How many pills or doses does your child take at
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed

What pharmacy do you use for your child? \_\_\_\_\_

What over-the-counter medicines, does your child take regularly?

Vitamins

Herbal medicine (please list) \_\_\_\_\_

Other (please list) \_\_\_\_\_

None. My child does not take any over-the-counter medicines regularly.

**Does your child have any allergic reaction (bad effect) from any of the following? (Check all that apply.)**

Outside or Indoor allergies (for example: grass, pollen, cats ...)

Food Allergies (for example: peanuts, milk, wheat ...)

Medicine or shots (immunization). (Please list below.)

No, my child has no allergies that I know of.

Medicine child is allergic to	What happened when your child took the medicine?

**Please list the previous Medical Providers your child has seen** \_\_\_\_\_

**Please check any of the following medical problems that your child has ever had.**

Ear infections	Yes	No
Nose problems (sinus infections, nose bleeds)	Yes	No
Eye problems (blurry vision, wears glasses)	Yes	No
Hearing problems	Yes	No
Mouth or throat problems (Strep throat, swallowing problems)	Yes	No
Diarrhea (having frequent and runny bowel movements)	Yes	No
Constipation (problems having a bowel movement )	Yes	No
<b>Vomiting</b>	Yes	No
Problems <b>urinating</b> (bed wetting, pain when urinating)	Yes	No
Back problems (crooked back, back pain)	Yes	No
Growing pains (bone or body pains due to growing)	Yes	No
Muscle and bone problems (weak muscles, pain in joints)	Yes	No
Skin problems (acne, flaking skin, rashes, hives)	Yes	No
<b>Seizures</b>	Yes	No
ADD/ADHD (problems paying attention, sitting still)	Yes	No
Sleeping problems (falling or staying asleep)	Yes	No

<b>Breathing</b> problems (cough, asthma)	Yes	No
<b>Warts</b>	Yes	No
<b>Jaundice</b> (yellow skin)	Yes	No

**Has your child received immunizations (shots) in the past?**

Yes

No

**Does anyone in the household smoke?**

Yes

No

The following questions are about the mother of the child during pregnancy and birth.

**Were any of the following used during pregnancy?**

Cigarettes

Alcohol

Illegal drugs (which ones? \_\_\_\_\_)

Prescription drugs (which ones? \_\_\_\_\_)

None of the above

**Did the mother have any of the following conditions or problems during pregnancy?**

Preeclampsia (high blood pressure)

Diabetes (sugar)

Emotional stress

Injury or serious illness

Unexpected bleeding or spotting

Other \_\_\_\_\_

**Was the birth:**

On the due date

Before the due date (by how much \_\_\_\_\_)

After the due date (by how much \_\_\_\_\_)

**Was the birth:** Vaginal C-Section

**Were any of the following used?**

Pain medicine during birth (epidural)

Tool to help pull baby out (forceps or vacuum)

None

Were there any problems during the birth? Yes No

If yes, please explain: \_\_\_\_\_

Was/is the child breastfed? Yes No If yes, how long \_\_\_\_\_

In the first 2 months after birth, did the child have:

Jaundice (yellow skin)

Colic (upset stomach, crying)

Breathing problems

Other \_\_\_\_\_

None of the above

At what age did the child begin to crawl? \_\_\_\_\_

At what age did the child begin to sit up? \_\_\_\_\_

At what age did the child begin to walk? \_\_\_\_\_

At what age did the child get his/her first tooth? \_\_\_\_\_

At what age did the child began to say words (mama, dada)? \_\_\_\_\_

How would you rate your child's health in his or her first year of life?

Excellent Very Good Good Fair Poor

Does the child go to school or daycare? Yes No If yes, what is its name?

If your child goes to school or daycare, describe how your child acts in school or daycare.

Check all that apply.

Nervous, worried Shy, withdrawn, keeps to self Hyper, restless, can't sit still

Gets angry easily Pushy, bullies others Scared, fearful

Relaxed, calm Moody Social, friendly

Happy

How are your child's grades in school?

Excellent OK Poor Does not go to school

About how much exercise does your child get every day?

Less than 30 minutes    30 minutes to 1 hour    Over 1 hour

**About how many hours of TV does your child watch every day?**

Less than 1 hour                      1-3 hours                      More than 3 hours

**About how many hours is your child on a computer every day?**

Less than 1 hour                      1-3 hours                      More than 3 hours

**About how many hours does your child spend outside every day?**

Less than 1 hour                      1-3 hours                      More than 3 hours

**About how many hours are spent reading with your child every day?**

Less than 15 minutes    15-30 minutes    30 minutes to 1 hour    More than 1 hour

**Does your child wear a helmet when riding a bike, roller blading, skate boarding, etc?**

Yes    No

**Does your child get buckled in a car seat or wear a seat belt when riding in a car?    Yes    No**

**Do you have guns in the home?    Yes    No**

**If yes, are they safely locked up?    Yes    No**

**What activities is your child involved in:**

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Too young to be involved in activities

**Please list what your child typically eats and drinks in a day:**

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**Check all the people that the child lives with:**

Mother

Father

Brothers (how many?\_\_)

Sisters (how many? \_\_\_\_\_)

Other family members (list \_\_\_\_\_)

Friends or other people (list \_\_\_\_\_)

Animals Dogs (how many? \_\_\_\_\_) Cats (how many? \_\_\_\_\_)

Other animals \_\_\_\_\_

**What medical problems do people in the child’s family have?**

Family Member	Medical Problems		
Parents:	Depression	Anxiety (nerve) problems	Learning disability
	Overweight	High blood pressure	Diabetes (sugar)
	Cancer	Heart problems	
	Other: _____		
Siblings:	Depression	Anxiety (nerve) problems	Learning disability
	Overweight	High blood pressure	Diabetes (sugar)
	Cancer	Heart problems	
	Other: _____		

**Minidoka Medical Center RHC / WorkMed**

1308 8<sup>th</sup> Street Suite 1 Rupert, Idaho 83350

(P) 208.436.4322 | (F) 208.436.1312

**Family Practice**

Jeffery Swenson, MD | Brian Muir, DO | Brad Wynn, DO | Cameron McHan, FNP-C | Aaron Catmull, FNP-C | Casie Taylor, FNP-C | Shawna McCaffrey, FNP | Rebecca Warnick, FNP / Charles Clair, MD

**Internal Medicine**

Kevin Owens, MD- FACP | Tyson Steel, DO

**Request for Medical Records**

**Provider requesting medical/health / billing records (Circle One):**

Assume Patient Care as (PCP)    Follow patient jointly    Send my medical records    Patient request own medical records

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

**Phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Work:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Where to request records from (Hospital, Clinic, or Dr. Office/s name and number/s)**

**Name of facility and doctor/s who provided services to you:**



Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Reason for request:** Labs, X-Ray, Pathology, Cultures Medications and Immunizations Office visit, ER, Hospital admit and discharge, Operative report, H&P Cardiac studies, Pulmonary Function, Sleep Study Billing

Other: \_\_\_\_\_

**Please send records via fax or ENCRYPTED email to the provided information below**

***Minidoka Medical Center, RHC***

*1308 8<sup>th</sup> Street Suite 1*

*Rupert, Idaho 83350*

*Office: (208) 436-4322 Fax: (208) 436-1312*

*mmcrhc@minidokamemorial.com (this is not a secure email, you must send encrypted file)*

**Patient Signature:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

If you are the patient's parent or personal representative who can legally sign, please fill out and sign below.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Address, if different from patient: \_\_\_\_\_

**Representative Signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

.....  
**Confidentiality Notice:** This document contains confidential information belonging to the sender. This information is legally privileged and intended only for the use of the individual, or entity named above.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents, is strictly prohibited. If you have received this Fax in error, please notify the sender immediately to arrange for destruction of the documents. Thank you.

***WHEN YOU ARE SEEN BY AN EMPLOYEE OR CONTRACTOR OF THE CLINIC, YOU HAVE THE RESPONSIBILITY TO:***

Treat the staff with consideration, respect and dignity.

Understand that your life-style does affect your health.

Take an active part in your health care.

Follow the agreed upon treatment plan. If you choose or are unable to follow the treatment plan, it is your responsibility to inform the Medical Provider.

Observe facility rules and regulations that are for the safety and consideration of all patients and staff.

Provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications, advance directives (living wills or durable power of attorney), and other matters relating to your healthcare.

Report whether you understand a contemplated course of action and what is expected of you.

***WHEN YOU ARE SEEN BY AN EMPLOYEE OR CONTRACTOR OF THE CLINIC, YOU HAVE THE RIGHT TO:***

Be treated with consideration, respect and dignity;

Have the confidentiality of your medical information protected, to have privacy act regulations enforced, and to have these areas of confidentiality explained to you in language you can understand;

Have privacy during case discussion, counseling & treatment;

Review your records in the presence of a healthcare professional;

Know the name and qualifications of staff providing your care;

Know your diagnosis, health problems, test results, the potential advantages and risks of treatment or procedures in language you can understand;

Expect that all services, treatment and counseling techniques will take place with your informed consent;

Participate in referral planning;

Have access to the patient comment procedure;

Refuse to participate in research.

Have another individual present in the exam room with you, if you so desire.



Minidoka Memorial Hospital, Minidoka Medical Center RHC, and Mini-Cassia Surgical and Specialty Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Minidoka Memorial Hospital does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

If you need language services, come in to our Emergency Department where our staff can assist you, or call our operator at (208) 436 – 0481.

If you believe that MMH has failed to provide adequate language services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail, fax or email. If you need help filing a grievance, our Emergency Department or Business Office staff is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509f, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

### **English**

ATTENTION: If you speak a language other than English, language assistance services are available to you at our Emergency Department.

### **Español (Spanish)**

ATENCIÓN: Si habla un idioma que no sea inglés, los servicios de asistencia lingüística están disponibles para usted en nuestro Departamento de Emergencias.

### **中文 (Chinese)**

注意: 如果您使用英語以外的其他語言, 我們的急診室將為您提供語言幫助服務

### **Српско-хрватски (Serbo-Croatian)**

ПАЖЊА: Ако говорите неким другим језиком осим енглеског језика, службе за помоћ у вези са језиком су вам на располагању у нашем одељењу за хитне случајеве.

### **한국어 (Korean)**

주의: 영어 이외의 언어를 사용하는 경우 응급실에서 언어 지원 서비스를 이용할 수 있습니다.

### **नेपाली (Nepali)**

ध्यान: यदि तपाईं अ English-प्रेजी बाहेक कुनै भाषा बोल्नुहुन्छ भने भाषा सहयोग सेवाहरू तपाईंलाई हाम्रो आपतकालीन विभागमा उपलब्ध छन्।

### **Tiếng Việt (Vietnamese)**

CHÚ Ý: Nếu bạn nói một ngôn ngữ khác tiếng Anh, các dịch vụ hỗ trợ ngôn ngữ có sẵn cho bạn tại Khoa Cấp cứu của chúng tôi.

### **عربي (Arabic)**

تنبيه: إذا كنت تتحدث لغة أخرى غير اللغة الإنجليزية، فإن خدمات المساعدة اللغوية متاحة لك في قسم الطوارئ لدينا.

### **Deutsche (German)**

ACHTUNG: Wenn Sie eine andere Sprache als Englisch sprechen, stehen Ihnen in unserer Notaufnahme Sprachunterstützungsdienste zur Verfügung.

### **Tagalog (Tagalog)**

Pansin: Kung nagsasalita ka ng isang wika maliban sa Ingles, ang mga serbisyong pantulong sa wika ay magagamit sa iyo sa aming Kagawaran ng Pang-emergency.

### **русский (Russian)**

ВНИМАНИЕ: Если вы говорите не на английском языке, вам доступны услуги языковой помощи в нашем отделении неотложной помощи.