Minidoka Memorial Hospital

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_____
First MI Last

Date of Birth _____/_____/_____ SSN_____ 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)

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
___Kevin Owens, MD FACP
___Tyson Steel, DO
___Brad Wynn, DO

Primary Insurance _____
ID Number _____Group # _____
Name of Insured _____ Birth-date of Insured _____
Relationship to pt. _____SSN of insured: _____
Amount of deductible $_____ or Co-Pay $_____

Secondary Insurance _____
ID Number _____Group # _____
Name of Insured _____ Birth-date of Insured _____
Relationship to pt. _____SSN of insured: _____
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

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* □	*What happens?*

Medications	*None* □	*Strength*	*How many times a day do you take it?*

Please attach another paper if needed

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
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		
BLADDER PROBLEMS? Y N	URINARY LEAKAGE? Y N	

Name_____
DOB_____

	Personal History Current and Past	Family Medical History
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?___ When was your last menstrual period?_____ Have you had a hysterectomy? Y N Last pap smear? _____ Your last mammogram?_____		
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:		

Previous hospitalizations: _____

Family History:

Father: Living □ Deceased □ How old when he passed away and why?_____

Fathers health condition/s:_____

_____

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

Mothers health condition/s: _____

_____

Number of Brother: _____ Health Problems:_____

Number of Sisters: _____ Health Problems:_____

Name_____
DOB_____

Preventative

	Colonoscopy	Bone Density	Mammo	PAP	PSA	Eye Exam	Foot Exam	Rectal Exam	Dental Cleaning
Date									
Normal									
Abnormal									
Due Date									

Surgical History and Dates:_____

Social History

Occupation:

Employed □ Place of Employment_____ Unemployed □ Retired □ Homemaker □ Disabled □ Student □

Marital Status:

Married □ Single□ Divorced □ Separated □ Widowed □ Widowed but remarried □ Significant Other □

Sexually Active: Yes □ No □ Multiple Partners □ Birth control □ Condoms □ Other_____

Number of children _____ Number who are male_____ Number who are female_____ Miscarriage/s_____

Activity Status: Athletic □ Active/Fit □ Occasionally/Rarely □ Never □ Ideal body weight for you_____

Tobacco Products/Nicotine: None□ Cigarettes □ Cigars □ Smokeless/Chew □ E-cigarette/ Vape □
Currently use□ How many per day_____ How many years smoked_____ Quit□ Quit Date_____

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

Caffeinated Products: Coffee□ # /day____ Tea□ #/day____ Soda Pop□ #/day____ Energy Drink□ #/day____

Illegal Drugs: None□ Marijuana□ Methamphetamines □ Cocaine□ Other_____

Experimented with □ Currently Use □ Quit □ When did you quit_____ Rehabilitation □ Self Recovery □

Mental Health History

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 □

Pharmacy:_____

Patient Signature_____ **Date**_____

Minidoka Medical Center RHC / WorkMed

1308 8th 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 8th 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: _____

.....

WHEN YOU ARE SEEN BY AN EMPLOYEE OR CONTRACTOR OF THE CLINIC, YOU HAVE THE <u>RESPONSIBILITY</u> 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 <u>RIGHT</u> 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

Discrimination is Against the Law

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 English्रेजी 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.

عربى (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.