Rankin Rural Medical Clinic
Commitment to Community

Patient Information:

Date: _____ Name: _____ DOB: ___/____/_____

Address: _____City/ST:_____ Zip_____

Sex: M or F Marital Status:_____ Race:_____ SSN:_____

Home Phone: _____ Cell Phone:_____

Email Address :_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Place of employment: _____ Work Phone: _____

Preferred Pharmacy:_____ City/ST:_____

Primary Insurance:

Policy Holder:_____ Relationship to Policy Holder:_____

DOB of Policy Holder:____/_____/_____ SSN of Policy Holder:_____

Insurance Company:_____ ID #:_____ Group #_____

Secondary Insurance

Policy Holder:_____ Relationship to Policy Holder:_____

DOB of Policy Holder:____/_____/_____ SSN of Policy Holder:_____

Insurance Company:_____ ID #:_____ Group #_____

Authorization:

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Rankin Rural Medical Clinic providers all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether paid by insurance or not. I authorize the use of my signature on all insurance submissions. Rankin Rural Medical Clinic providers may use my healthcare information and may disclose such information to the above-named insurance company for obtaining payment for services and determining insurance benefits. Rankin Rural Medical Clinic providers may also obtain a prescription history from external sources if needed. By signing below, I am aware and understand all information above.

_____ _____

Signature of Patient, Parent or Guardian Date of Signature

Patient Authorization for Contact

Please print all information and then sign and date at the bottom of this page.

I, _____, authorize Rankin Rural Medical Clinic to disclose my protected

health information to the following persons by the following means:

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

This authorization will remain in effect until terminated by the patient, the patient's personal representative, or another individual of legal entity authorized to do so by court order. This can be done in person or by mailing a certified request to 129 Center St Suite B, Richland, MS, 39218.

Patient Signature: _____ Today's Date:_____

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Acts of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct/indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g., my insurance company)
- The day-to-day healthcare operations of our practice

I have also been informed of, and given the rights to review and secure a copy of the Privacy Practices, which contains a more complete description of the uses and disclosures of my protected healthcare information, and my rights under the HIPAA. I understand that you reserve the right to change the terms of this notice at any time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my health information is used and disclosed to requested restrictions. However, if you agree, you are bound to comply with this restriction.
I understand that I may revoke consent, in writing, at any time. However, any use or disclosure that occurred prior to this date, will not affect revoke of this consent.

Printed Patient Name: _____

Relationship to Patient (if other than patient): _____

Signature: _____ Today's Date: _____

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Patient Medical Information

Name: _____ DOB: _____/_____/_____

Past Medical History:

List any medical issues diagnosed by a Medical Professional:

_____

_____

_____

Circle if you have had any of the following:

Asthma	COPD/ Emphysema	Diabetes
High Blood Pressure	Rheumatoid Arthritis	Depression
Blood Clots	Stroke	Anxiety
Cancer- Type: _____	Thyroid Disease	Heart Disease
Liver Disease	Heart Murmur	Ulcers
High Cholesterol	GERD/Reflux	Kidney Disease
Epilepsy/Seizures	Anemia	High Cholesterol

List any past surgeries/procedures:

_____

_____

_____

Family History:
List any medical problems and the family member diagnosed:

Diagnosis: _____ Family Member: _____

Diagnosis: _____ Family Member: _____

Diagnosis: _____ Family Member: _____

Social History:

Do you smoke? Y or N If so, how often? _____ Former Smoker? Y or N

Alcohol Use? Y or N If so, how often? _____ If yes, how long? _____

List your prescribed and over the counter medications:

Medication Name:	Dose/Strength:	How many times taken per day:

Allergies to Medications:

Name of Drug: _____ Reaction to Drug: _____

Name of Drug: _____ Reaction to Drug: _____

Name of Drug: _____ Reaction to Drug: _____

Gynecological History (For Females Only)

How many times have you been pregnant? _____ Date of last Pap smear: _____

What was the date of your last menstrual cycle? _____

Have you had an abnormal Pap? _____ If so, diagnosis: _____ When: _____

Have you had a sexually transmitted disease? Y or N If so, diagnosis? _____

Date of last mammogram: _____ Results: _____

Have you had a breast biopsy? Y or N If so, when? _____ Results: _____