Riceland HEALTHCARE™
"Advanced Healthcare Made Personal"

ACKNOWLEDGEMENT OF RECEIPT
FOR NOTICE OF PRIVACY PRACTICE

You the patient, have certain rights under the federal privacy standards. These rights include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communication concerning your medical condition and treatment.
- The right to inspect and copy your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

We, Riceland Medical Center, are required by law to maintain the privacy of your health information and to provide you with a copy of privacy practice.

We, Riceland Medical Center, also are required to abide by the privacy policies and practices that are outlined in this notice.

_____
Patient Signature Acknowledges Receipt of Above Information

_____/_____/_____
Date

If patient is unable to sign the above Acknowledgement, legal guardian may sign.

_____
Legal Guardian

_____/_____/_____
Date

Reason Signature acknowledge receipt of Notice of Privacy Practice could not be obtained:

Individual refused to sign
Communication barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining the acknowledgement
Other (please specify) _____

Effective 08/02/2010

Riceland Medical Center
REGISTRATION

Patient Information:

_____ /_____

(First, Middle, Last Name) (Date of Birth) (Social Security Number)

_____

(Address) (City, State, Zip Code) (Area Code- Home Phone Number)

_____

(Area Code- Work Phone Number) (Nickname) (Cell Phone Number)

SINGLE MARRIED DIVORCED WIDOWED MALE/ FEMALE

EMPLOYED PART-TIME STUDENT FULL-TIME STUDENT OTHER

Employment Information:

_____

(Occupation) (Employer)

_____

(Billing Address) (City, State, Zip Code)

Spouse Information:

_____ /_____

(First, Middle, Last Name) (Date of Birth) (Social Security Number)

_____

(Employer) (Work Phone Number)

Responsible Person *(If* Applicable):

_____/_____

(First, Middle, Last Name) (Date of Birth) (Social Security Number)

_____

(Address) (City, State, Zip Code) (Area Code-Home Phone Number)

_____

(Employer & Phone Number) (Relationship to Patient)

Emergency Contact (Someone Not Living in Home of Patient)

_____

(Name) (Phone Number) (Relationship to Patient)

_____

(Address) (City, State, Zip Code)

Insurance Information: Primary Insurance

_____/_____

(Name of Insured) (Date of Birth) (Relationship to Patient)

_____

Insurance Company) (Group Number) (ID Number)

Secondary Insurance:

_____/_____

Name of lnsured (Date of Birth) (Relationship to Patient)

_____

Insurance Company) (Group Number) (ID Number)

How were you referred to our office? **Doctor Patient** (Name of source)_____

Is your illness or injury related to any of the following: **Employment Emergency Accident Auto Accident**

If auto accident, please print state where accident occurred._____

Notice of Privacy Receipt:

I acknowledge that I was provided with the Notice of Privacy Practices of Riceland Medical Center.
Print Name of Patient:_____
Signature of Patient:_____
Patient's Date of Birth:_____
(For Person Representative if applicable)
Printed Name of Personal Representative:_____
Relationship to Patient:_____
Signature of Personal Representative:_____
Date:_____

SPECIFIC CONSENT FOR RELEASE OF PATIENT INFORMATION:

I,_____(Responsible person if minor), understand that I am giving consent of release of the approved information listed below for the duration of one year to the following person/persons:

(Name) Relationship to the patient

(Name) Relationship to the patient

(Name) Relationship to the patient

____ I authorize the release of any test results. _____(Patient Initials)
____ I authorize the discussion of symptoms or complaints with medical staff _____(Patient Initials)
____ I authorize the release of medical information along with directions and instructions. _____(Patient Initials)
____ I authorize the use of any home answering machine for any medical information and correspondence in reference to my medical records. _____(Patient Initials)

Release of Medical Record Information:

I,____(initial)understand that I may only request medical records that are generated through the practice of Riceland Medical Center. I understand records brought to the clinic from another doctor will not be released back to me

Consent to Treatment:

_____(Patient Initials, Responsible Person if Minor) I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examinations, and treatment.

Financial Responsibility and Assignment of Benefits:

_____(Patient Initials, Responsible Person if Minor) I agree to pay all charges for medical and health care services not covered by my insurance company.

I CERTIFY THAT I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS.

_____/_____/_____
(Signature of Patient or Other Legally Authorized Person) (Date)

_____/_____
(Signature of Witness-Clinic Employee) (Date)

Riceland Medical Center

History & Physical

Please fill out this form entirely, to the best of your knowledge.

Last Name:_____ First Name:_____ Middle:_____

Occupation:_____ SS#:_____ Age:_____ DOB_____

Last Primary Care Doctor:_____

Phone:_____

Last Visit Date:_____

If you see any specialists, please list them here:

_____

_____

Surgeries, Illnesses & Injuries

Please indicate any surgeries and include any not listed.

NONE	___/___/___	Hysterectomy	___/___/___	Complete or Partial (circle)
Bypass	___/___/___	C-Section	___/___/___	
Stents	___/___/___	Joint/Hip	___/___/___	
Valve Replace	___/___/___	Appendix	___/___/___	
Gallbladder	___/___/___	Hernia	___/___/___	
Tonsillectomy	___/___/___			
Other	___/___/___	_____		
Other	___/___/___	_____		

Please list any injuries or illnesses that may or may not have required a hospital stay with dates.

_____

_____

Family History

Please note ANY family history (parents, grandparents, siblings, children; Living or Deceased) for the following conditions:

Disease Condition:	No	Yes	?	Relationship to You/ Onset Date
Tuberculosis	□	□	□	_____
Glaucoma	□	□	□	_____
Arthritis	□	□	□	_____
Cancer	□	□	□	_____
Diabetes	□	□	□	_____
Heart Disease	□	□	□	_____
High Blood Pressure	□	□	□	_____
Kidney Disease	□	□	□	_____
Epilepsy	□	□	□	_____
Thyroid Disease	□	□	□	_____
Stroke	□	□	□	_____
Aids/HIV	□	□	□	_____
Mental Illness	□	□	□	_____
Asthma or Lung	□	□	□	_____

History & Physical

Social Historv

Do you drive? No □ Yes □

Do you use Tobacco products? No □ Yes □

If yes, Type / Amount / How long?_____

Do you drink Alcohol? No □ Yes □

If yes, Type / Amount / How long?_____

Do you use illegal drugs? No □ Yes □

If yes, Type / Amount / How long?_____

Do you sleep well at night? No □ Yes □

Do you exercise? No □ Yes □

Do you drink coffee? No □ Yes □

When was the last year of Tetanus Shot?_____

Have you ever been exposed/infected with:

□Gonorrhea □ Hepatitis □HIV □Syphilis

Review of Systems

Do you currently or have you ever had any problems in the following areas:

	No	Yes	?		No	Yes	?
Fever, weight Joss/gain	□	□	□	Allergies/Hay fever	□	□	□
Skin	□	□	□	Sinus Congestion	□	□	□
Headaches	□	□	□	Post Nasal Drip	□	□	□
Migraines	□	□	□	Chronic Cough	□	□	□
Seizures	□	□	□	Dry Throat/ Mouth	□	□	□
Constipation	□	□	□	Asthma	□	□	□
Diarrhea	□	□	□	Emphysema	□	□	□
Thyroid/ Other Glands	□	□	□	Chronic Bronchitis	□	□	□
Genital/Kidney/Bladder	□	□	□	Diabetes	□	□	□
Anemia	□	□	□	Hypertension	□	□	□
Bleeding Problems	□	□	□	Chest Pain	□	□	□
Allergies/Immunities	□	□	□	Rheumatoid Arthritis	□	□	□
Psychiatric	□	□	□	Muscle/Joint Pain	□	□	□

If you answered YES to any of the above or have a condition not listed, please explain & list medications.

_____

_____

_____

_____

_____

_____

_____

_____

_____

History & Physical

Preventative Screening

Please indicate the last date any of these tests were performed:

Bone Density Screening	___/___/___
Cardiac Stress Test	___/___/___
Chest X-Ray	___/___/___
EKG	___/___/___
Colonoscopy	___/___/___
Mammogram	___/___/___
PSA Screen	___/___/___
Well Woman Exam	___/___/___

Do you have any active Advanced Directives? If so, please bring in a copy so we can add it to your chart.

Do you use any Medical Devices? Please circle if applicable:

Bathtub Rails	Brace	Dentures	Pacemaker	Treadmill
Glucose Monitor	Cane	Stationary Bicycle	Walker	Oxygen
Blood Pressure Cuff	Crutches	Glasses or Contacts	Support Stockings	Wheelchair
Knee Replacement-	Left	Right	Both	
Hearing Aid-	Left	Right	Both	
Hip Replacement-	Left	Right	Both	

Patient Signature:_____ Date:___/____/____

Minor:_____

Guardian Signature/Relationship:_____ Date:___/____/____