

Patient Information and Consent

What is the reason for your visit today?	
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Patient information				
Last Name	First Name	Date of Birth	Social Security #	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Permanent Mailing Address		City, State ZIP		
Email Address		Primary Phone	Phone Type <input type="checkbox"/> Home <input type="checkbox"/> Cell	
Preferred Language		Race <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Prefer not to answer		
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino				
Emergency Contact Name		Relationship to Patient	Emergency Contact Phone	

Guarantor/Responsible Party (person responsible for payment)		
Legal Name of Responsible Party (First, Middle, Last)		Social Security Number
Mailing Address (City, State, Zip)		Phone Number
Email Address (if different from the patient email above)	Relationship to Patient	Date of Birth

Authorization for Release of Information
May we leave testing results or referral information in email? <input type="checkbox"/> Yes <input type="checkbox"/> No
May we leave testing results or referral information in voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No
May we contact you via text message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of person who may receive information on your behalf regarding testing or referrals

Primary Insurance Name	
ID/Subscriber Number	Group Number
Subscriber Name & Relationship to Patient	Subscriber Date of Birth

Secondary Insurance Name	
ID/Subscriber Number	Group Number
Subscriber Name & Relationship to Patient	Subscriber Date of Birth

Patient Employment Information	
Employer Name	Employer Phone Number
Employer Address (City, State, Zip)	Phone Number



Patient Medical History

Today's Date: _____

Patient information			
Patient Name	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth Gender

Patient History	
INDICATE ANY CONDITIONS YOU ARE CURRENTLY BEING TREATED FOR OR HAVE HAD IN THE PAST:	
<input type="checkbox"/> Head/brain injuries or illnesses (e.g., concussion)	<input type="checkbox"/> Diabetes or blood sugar problems
<input type="checkbox"/> Seizures, epilepsy	<input type="checkbox"/> Anxiety, depression, nervousness, or other mental health problems
<input type="checkbox"/> Eye problems (except glasses or contacts)	<input type="checkbox"/> Fainting or passing out
<input type="checkbox"/> Ear and or hearing problems	<input type="checkbox"/> Dizziness, headaches, numbness, tingling, or memory loss
<input type="checkbox"/> Heart disease, heart attack, bypass, or other heart problems	<input type="checkbox"/> Unexplained weight loss
<input type="checkbox"/> Pacemaker, stents, implantable devices, or other heart procedures	<input type="checkbox"/> Stroke, mini-stroke (TIA), paralysis, or weakness
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Neck or back problems
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Bone, muscle, joint or nerve problems
<input type="checkbox"/> Chronic (long-term) cough, shortness of breath or other breathing problems	<input type="checkbox"/> Blood clots or bleeding problems
<input type="checkbox"/> Lung disease (e.g., asthma)	<input type="checkbox"/> Cancer
<input type="checkbox"/> Kidney problems or stones, or pain/problems with urination	<input type="checkbox"/> Chronic (long term) infection or other chronic diseases
<input type="checkbox"/> Stomach, liver or digestive problems	<input type="checkbox"/> Sleep disorders, pauses in breathing while asleep, daytime sleepiness or loud snoring

Allergies (include medication, food, latex and environmental allergies)			No known allergies <input type="checkbox"/>
Allergy to:			
Severity:	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Reaction:			

Current Medication (include non-prescription products)				No current medications <input type="checkbox"/>
1.	3.	5.	7.	
2.	4.	6.	8.	

Preferred Pharmacy	
Pharmacy Name	Pharmacy Location/Phone Number

Procedures / Surgeries				No procedures or surgeries <input type="checkbox"/>
Surgery / Procedure #1	Approximate Date	Surgery / Procedure #3	Approximate Date	
Surgery / Procedure #2	Approximate Date	Surgery / Procedure #4	Approximate Date	



Patient Name	Date of Birth
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Preventative Screening	Have you had a:	Not applicable <input type="checkbox"/>
Colonoscopy/Cologuard?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date:	
Mammogram?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date:	
DEXA Scan?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date:	
Pap Smear?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date:	

Women's Health	Not applicable <input type="checkbox"/>
When was your most recent menstrual cycle? Date:	Are you pregnant or possibly Pregnant?

Family History	
<ul style="list-style-type: none"> - Head/brain injuries or illnesses (e.g., concussion) - Seizures, epilepsy - Eye problems (except glasses or contacts) - Ear and or hearing problems - Heart disease, heart attack, bypass, or other heart problems - Pacemaker, stents, implantable devices, or other heart Procedures - High blood pressure - High cholesterol - Chronic (long-term) cough, shortness of breath or other breathing problems - Lung disease (e.g., asthma) - Kidney problems or stones, or pain/problems with urination - Stomach, liver or digestive problems 	<ul style="list-style-type: none"> - Diabetes or blood sugar problems - Anxiety, depression, nervousness, or other mental health problems - Fainting or passing out - Dizziness, headaches, numbness, tingling, or memory loss - Unexplained weight loss - Stroke, mini-stroke (TIA), paralysis, or weakness - Neck or back problems - Bone, muscle, joint or nerve problems - Blood clots or bleeding problems - Cancer - Chronic (long term) infection or other chronic diseases - Sleep disorders, pauses in breathing while asleep, daytime sleepiness or loud snoring
Please list any of the following conditions below if they pertain to a family member	

Mother	History: _____	<input type="checkbox"/> N/A
Father	History: _____	<input type="checkbox"/> N/A
Sister	History: _____	<input type="checkbox"/> N/A
Sister	History: _____	<input type="checkbox"/> N/A
Brother	History: _____	<input type="checkbox"/> N/A
Brother	History: _____	<input type="checkbox"/> N/A

Grandmother (M)	History: _____	<input type="checkbox"/> N/A
Grandmother (P)	History: _____	<input type="checkbox"/> N/A
Grandfather (M)	History: _____	<input type="checkbox"/> N/A
Grandfather (P)	History: _____	<input type="checkbox"/> N/A

Other Health Issues

Do you drink alcohol? Yes No Beer Wine Liquor _____ per week

Do you smoke cigarettes? Yes No If yes, _____ per day, _____ years of use

Do you use other forms of tobacco? Yes No Pipe Cigar Snuff/Chew

Do you vape or use an e-cigarette? Yes No If yes, _____ per day, _____ years of use

Marijuana / recreational drug use? Yes No If yes, _____ per day, _____ years of use

Immunizations

Influenza (18 years of age and older) Yes No If yes, date: _____

Pneumococcal (65 years of age and older) Yes No If yes, date: _____

Tetanus (Tdap) Yes No If yes, date: _____

COVID-19 Yes No Number of shots: _____ Date of most recent: _____

Shingles Yes No If yes, date: _____



GENERAL CONSENT

Onsite Provider

I acknowledge I have been informed that a healthcare provider may not be physically present in the facility 24 hours per day 7 days per week; however, a qualified healthcare provider is available to me for urgent medical needs and emergencies 24 hours per day, 7 days per week.

Informed Consent for Treatment/Consultation/Medical Services

I request and authorize Mountrail County Medical Center (MCMC), including but not limited to all facilities and services (MCMC-Critical Access Hospital, MCMC-Rural Health Clinic), its agents and employees, along with my physicians, their associates, and assistants who may attend to me during this episode of medical care to perform routine medical tests and procedures, provide medication, medical care, etc., for my health and wellbeing. This may also include telehealth/telemedicine services if my healthcare providers feel it is medically appropriate. I understand that I will be given information about test(s), treatment(s), and procedures, as applicable, including the benefits, risks, possible problems or complications, and alternate choices for my medical care. I recognize that I have the right to reasonable informed participation in decisions involving my health care. I understand obtaining my informed consent for a proposed treatment or procedure is the responsibility and obligation of my attending provider or other provider(s) authorized by me to perform the treatment or procedures. I agree to discuss any concerns with my treating provider.

Medical Release of Information

I hereby authorize MCMC to furnish information, either concurrently or retrospectively, from my medical record, to any insurer, compensation carrier, health care facility, regulatory agency, or provider agency of financial assistance. This information may also be furnished to referral or consulting physicians or health care facilities responsible for my subsequent medical care. The information may be used for diagnosis, treatment, therapy, follow-up and/or education. I understand the laws that protect the privacy and confidentiality of health information apply to all my personal health information. Information obtained during my visit that identifies me will not be given to anyone without my consent except for the purposes of treatment, education, billing, and healthcare operations. By agreeing to receive services, I am consenting to MCMC sharing my protected health information with certain third parties as more fully described in MCMC privacy policy. I understand, agree, and expressly consent to MCMC obtaining, using, storing, and disseminating to necessary third parties, information about me, including written and electronic information or images and videos, as necessary to provide face to face or telehealth services.

Electronic Health Record

I understand that MCMC utilizes an electronic health record (EHR) to maintain my protected health information. This EHR will be stored within the Cerner Electronic health record through Trinity Healthcare systems.

Contact Information/Portal Use/Phone numbers/Mail/eMail

I authorize MCMC and/or their affiliates to contact any telephone/cellular numbers I have provided to confirm appointments or collect or discuss payment due. This contact may be made by third parties and/or auto-dialers not excluding physical mail and/or email. By providing and signing this consent form, I authorize the above contact procedures.

Telehealth/Telemedicine

I understand telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patients' medical information for the purpose of improving patient care, which may include primary care practitioners, specialists and/or subspecialists, nurse practitioners, registered nurses, and other healthcare providers who are part of my clinical care team. In addition to myself and the members of my clinical care team, my family members, caregivers, or other legal representatives or guardians may participate in my medical care if I agree. I understand telehealth requires transmission, via Internet or tele-communication device, of health information. I hereby consent to the use of telehealth/telemedicine in the provision of care and the above terms and conditions. As with any internet-based communication, I understand that there is a risk of security breach. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. Individuals other than my clinical care team or consulting providers may also be present and have access to my information for the telehealth/telemedicine session so they can operate or repair the video or audio equipment used. These people will adhere to applicable privacy and security policies.

I hereby release and hold harmless MCMC and all members of my care team from any loss of data or information due to technical failures associated with the telehealth/telemedicine service.

Personal Property/ Valuables

I understand and acknowledge that MCMC assumes no responsibility for personal possessions, the following is kept at my own risk including but not limited to cash, jewelry, bridgework, eyeglasses, hearing aids, and any/all other personal possessions/ personal property which I choose to keep with my person in any department or room of the MCMC facility.

Financial Agreement

I hereby agree to pay MCMC their charges, including co-payments, deductibles, and coinsurance for all services rendered during this medical treatment or hospitalization. I acknowledge and understand that I and any guarantor signing on my behalf are personally responsible for all charges not otherwise paid by assignment of insurance benefits. I also certify, any information given in applying for coverage under the Social Security Act, any insurance or other information I have provided is true and correct. I understand charges/bills for facility and professional services and/or other providers may come in separate statements.

I acknowledge that I may request a copy of the **Plain Language Summary** of MCMC's financial assistance policy. *I acknowledge, upon my request, I will be given a copy of Mountrail County Medical Center's Notice of Privacy Practices, and Patient Rights and Responsibilities.*

By signing below, I certify that I am the legal representative of the participant or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understand the above statements. I have had all my questions answered. I understand that this informed consent will become part of my medical record.

Signature of Patient/Legal Representative

Relationship (if not patient)



CONSENT TO DISCUSS MEDICAL CARE

Patient Name (please print): _____ Date of Birth: _____

I authorize Mountrail County Medical Center to discuss my medical information or that of my minor child with the following individuals I have listed below. (Please print)

Name: _____ Relationship: _____

Phone#: _____

This authorization remains valid for one (1) year.

Patient or Guardian Signature

Date

Signature of Staff

Date/Time

