DELHI RURAL HEALTH CLINIC

508 Broadway Street, Delhi, LA 71232
Phone: (318) 878-3737
Fax: (318) 878-9682

Jose R. Enriquez, M.D.
Dung Nguyen Le, M.D.
K.E. McDonald, III, M.D.
Cynthia Wagnon, M.D.
Recel M. Harris, RN, FNP
Alisha McVay, APRN, FNP
Deanna Thomason, APRN, FNP
Debbie Sparks, APRN, FNP

Dear New Patient,

Thank you for your interest in wanting to become an established patient here at the Delhi Rural Health Clinic. To ensure that this process is completed in a timely manner, please be sure to read everything carefully and complete the application, leaving nothing unchecked. If any part of this application is not complete it will be returned to you and will delay the process in finding you a primary care physician.

If you have any questions or need help filling out the paperwork, please feel free to call and someone will gladly assist you.

Sincerely,
Delhi Rural Health Clinic

Pt # ____________

DELHI RURAL HEALTH CLINIC
PATIENT DEMOGRAPHIC INFORMATION

Date: _______/________/_______ Preferred Pharmacy: ____

Patient's Last Name: ________________________ First Name____________________ MI ______ JR. SR. III

DOB: _____/______/_____ SSN# ______-______-_______ Guardian (under 18 yrs.) __________________

Mailing Address: _________________________________City:_______________ State: _____ Zip: _______

Home (_____) _______-________ Cell (_____) _______-________ Work (_____) _______-_______

Email address: ____

*** Children under 18 years of age MUST be accompanied by an adult***

Guardian Last Name: _______________________________ First Name: ____________________________

Address: ____City_________________________State________

Home (_____) _______-________ Cell (_____) _______-________ Work (_____) _______-_______

DOB: _____/______/_____ SSN# ______-______-_______ Relationship to Patient: ___________________

Emergency Contact Last Name: _____________________________ First Name: ________________________

Address: ____City_________________________State________

Home (_____) _______-________ Cell (_____) _______-________ Work (_____) _______-_______

Relationship to Patient: ☐Self ☐Parent ☐Spouse ☐Grandparent ☐Sibling ☐Other ____________

INSURANCE INFORMATION

Insurance Company Name: ____

Policy #: _____________________________________ Group #: ____________________________________

Policy Holder's Last Name: ______________________ First Name: __________________________ MI: ____

Policy Holder's Date of Birth: _____/______/_____ Policy Holder's SSN: ______-______-_______

Policy Holder's Address: _________________________________City____________________State________

If Medicaid, PCP (Referring Dr.) ____

Insurance Company Name: ____

Policy #: _____________________________________ Group #: ____________________________________

Policy Holder's Last Name: ______________________ First Name: __________________________ MI: ____

Policy Holder's Date of Birth: _____/______/_____ Policy Holder's SSN: ______-______-_______

Policy Holder's Address: _________________________________City____________________State________

If Medicaid, PCP (Referring Dr.) ____

Pt #__________________

Check one box next to each question

Sex: ☐Male ☐Female **Ethnicity:** ☐Hispanic ☐Non-Hispanic

Race: ☐White ☐Black ☐Hispanic ☐Asian ☐American Indian ☐Pacific Islander ☐Other ______

Language: ☐English ☐Spanish ☐Other __________________

Marital status? ☐Single ☐Married ☐Separated/Divorced ☐Widowed

Housing Status? ☐Homeless ☐Doubled Up ☐Street ☐Transitional ☐N/A

Are you a Veteran of the military? ☐Yes ☐No

Agricultural worker? ☐Yes ☐No

Where do you usually receive your healthcare? ☐Emergency Room ☐Hospital ☐Clinic ☐School Based

Has it been over 3 years since you have received healthcare? ☐Yes ☐No

FEMALE PATIENTS: ARE YOU PREGNANT OR COULD BE PREGNANT? YES or NO (WKS_____/MTHS_____)

HAVE YOU RECENTLY TRAVELED OUT OF THE U.S.A TO ANOTHER COUNTRY? YES OR NO

If yes please answer the following questions.

Have you recently visited Wuhan China? Y or N When? ______ /______/______

What country did you visit? ______________________ For how long? ___ days___wks___mths

Reason for Travel? Mission Vacation Business Education Medical Other____________

How did you Travel? Airplane Cruise Train

DO YOU HAVE ANY TRAVELER'S SYMPTOMS? (CIRCLE ALL THAT APPPLY)

- **Fever (the most important symptom)**
- Headache
- Abdominal pain
- Diarrhea
- Cough or shortness of breath
- Fatigue
- Skin rash
- Weight Loss

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE LET THE FRONT DESK KNOW IMMEDIATELY!

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DRHC CONSENT FOR TREATMENT

CONSENT FOR TREATMENT

I authorize Delhi Rural Health Clinic and such assistants as they may designate, to carry out diagnostic procedures if needed to better diagnose my condition and to administer such treatments and medications, as they determine necessary. I understand that my condition may call for a consultation with another Healthcare Provider. If this situation occurs, I authorize DRHC to relaease any medical information that may be needed to better provide for my medical treatment.

ASSIGNMENT AND RELEASE OF BENEFITS

☐ PRIVATE INSURANCE: I certify that I and/or my dependents have insurance coverage and assign directly to Delhi Rural Health Clinic all insurance benefits otherwise payable to me for services rendered. I understand I am responsible for all charges not paid by insurance. I authorize the use of my signature on all insurance submissions. The above physician/clinic may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services rendered.

☐ MEDICARE, MEDICAID, MEDIGAP: I request that payment of the authorized benefits be made either to me or on my behalf to Delhi Rural Health Clinic for any services furnished by this provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, Medigap Insurer, and their agents any information needed to determine these benefits for related services.

FINANCIAL AGREEMENT:

The undersigned understands and agrees that regardless of the patient's assigned insurance benefits the patient or responsible party is responsible for the total charges for services rendered, except for Medicare patients as set forth below, and further agrees that all amounts are due upon request and are payable to Delhi Rural Health Clinic. The undersigned further understands that should this account become delinquent and it becomes necessary for the account to be referred to an attorney or collection agency for collection or suit, the patient, as the designated responsible party, shall pay the reasonable attorney fees for collection expense.

NOTICE OF PRIVACY PRACTICES

I have been provided with a copy of the NOTICE OF PRIVACY PRACTICES for Delhi Rural Health Clinic and its' entities. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that Delhi Rural Health Clinic and its' entities may not be required to agree to the restrictions requested.

GENERAL OFFICE POLICIES

1. All co-pays and deductible amounts must be paid at the time of service.
2. All returned checks are subject to a service charge.
3. All delinquent accounts are automatically turned over to collection after 120 days if no response of payment is received.
4. All patients will be seen on a first come first serve basis, although Delhi Rural Health Clinic has the right to take patients with medical emergencies first.
5. This is a "SMOKE FREE" building. All smoking is prohibited.
6. No alcohol or drug use is allowed on the premises. Anyone abusing this policy will be asked to vacate the premises. If this request is not followed, Law Enforcement will be called.

My signature below indicates acknowledgemnt of receipt of the above information including (when applicable) a detailed NOTICE OF PRIVACY PRACTICES.

Patient/Patient Representative Signature	Witness Signature

Pt #________________

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*****PHYSICIAN REQUEST***** **In order to find a provider to serve you, please complete this form entirely.**

Date: _______/_______/_______ Preferred Pharmacy: ________________________________

Patient's Last Name: ________________________ First Name____________________ MI ______ JR. SR. III

DOB:_____/______/_____ SSN# ______-______-_______ Guardian (under 18 yrs) ________________

Mailing Address: __________________________________City:_______________ State: _____ Zip:_______

Home (_____)_______-________ Cell (_____)_______-________ Work (_____)_______-________

Email address: ____

PAYMENT METHOD (circle all that apply): Medicare Medicaid Private Insurance Self Pay

MEDICAL HISTORY ***Name of Doctor(s) Seen in Last 3 Years?** ________________________________

____

Current Illnesses:____

What medications are you currently taking? (List any additional on back of form)

________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

Allergies: ____

FEMALE PATIENTS: ARE YOU PREGNANT OR COULD BE PREGNANT? YES or NO (WKS_____/MTHS_____)

PAST MEDICAL HISTORY (circle all that apply)

Anemia	Depression	Seizure Disorder
Anxiety	Diabetes	Stroke
Arthritis	Heart Disease	Thyroid Disorder
Asthma	High Blood Pressure	Other: ____________________
Cancer	High Cholesterol	____________________
COPD	Kidney Disease	____________________

Past Surgeries : ____

____

Who referred you to us? ____

Pt #________________

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DATE: ________________________________

PATIENT'S NAME: ____ DOB:_____/______/_____

REQUESTED PHYSICIAN: ____

IS THERE A PHYSICIAN THAT YOU WOULD PREFER **NOT** TO SEE? ______________________________

~STAFF ONLY. DO NOT WRITE BELOW THIS LINE~

Office use only- please leave a brief explanation if patient is not accepted.

Dr. McDonald Y or N	Dr. Le Y or N	Dr. Enriquez Y or N
____________________	____________________	____________________
Dr. Wagnon Y or N	Recel Harris, FNP Y or N	Deanna Thomason, FNP Y or N
____________________	____________________	____________________

PT #________________

PATIENT INTAKE FORM

Patient Name:__________________________ DOB: ___/___/_____ Sex:_ M / F _ Race:__________

CHIEF COMPLAINT

Date: ______________ Reason for Visit:____

MEDICAL HISTORY **ALLERGIES:**____

DIAGNOSIS	Y	N	DIAGNOSIS	Y	N	DIAGNOSIS	Y	N	DIAGNOSIS	Y	N
CATARACTS			ASTHMA			STD			ANEMIA		
GLAUCOMA			COPD			HIV/AIDS			SICKEL CELL ANEMIA		
EYE GLASSES			PNEUMONIA			OVARIAN CYST			CANCER		
HEARING LOSS			GASTRIC REFLUX			ABNORMAL PAP SMEAR			GOUT		
SEASONAL ALLERGIES			CROHN'S DISEASE			ENDOMETROSIS			ARTHRITIS		
CHRONIC SINUSITIS			ULCERATIVE COLITIS			IRREGULAR PERIODS			ABSCESS/MRSA		
TONSILITIS			IBS			BACTERIAL VAGINITIS			TENDONITIS		
HEART ATTACK			HERNIA			ECTOPIC PREGNANCY			BURSITIS		
CONGESTIVE HEART FAILURE			LIVER DISEASE			INFECTED PROSTATE			OSTEOPOROSIS		
HYPERTENSION			KIDNEY STONES			ENLARGED PROSTATE			SEIZURES		
HIGH CHOLESTEROL			UTI			DIABETES			STROKE		
BLOOD CLOTS			RENAL DISEASE			THYROID DISEASE			MIGRAINES		

OTHER MEDICAL HISTORY:____

____

PREVIOUS SURGICAL HISTORY		PREVIOUS HOSPITALIZATIONS	
DATE	**PROCEDURE**	**DATE**	**DIAGNOSIS**

TOBACCO AND OTHER SUBSTANCE USE:		
SUBSTANCE	**Y**	**N**
TOBACCO		
ALCOHOL		
CAFFEINE		
DRUGS		

PREGNANCY HISTORY			
NUMBER OF PREGNANCIES			
NUMBER OF DELIVERIES			
C-SECTIONS		VAGINAL DELIVERIES	
MISCARRIAGES		ABORTION(S)	

PT #________________

FAMILY MEDICAL HISTORY - Mother, Father, Siblings, Paternal and Maternal Grandparents

DIAGNOSIS	Y	N	DIAGNOSIS	Y	N	DIAGNOSIS	Y	N
GLAUCOMA			HEPATITIS			SICKLE CELL DISEASE		
HEART DISEASE			LIVER DISEASE			CANCER		
HEART ATTACK			KIDNEY STONES			GOUT		
CONGESTIVE HEART FAILURE			RENAL DISEASE			ARTHRITIS		
HYPERTENSION			HIV/AIDS			ECZEMA		
HICH CHOLESTEROL			ENLARGED PROSTATE			OSTEOPOROSIS		
BLOOD CLOTS			DIABETES			SEIZURES		
ASTHMA			THYROID DISEASE			STROKE(CVA/TIA)		
COPD			ANEMIA			MIGRAINES		

OTHER FAMILY HISTORY:________________

HEALTH MAINTENANCE

SCREENINGS:				VACCINATION/IMMUNIZATION:			
SCREENING	DATE	ABNORMAL FINDINGS		VACCINE	UP TO DATE		DATE
COLONOSCOPY		Y	N	CHILDHOOD VACCINES	Y	N	
PAP SMEAR		Y	N	TETANUS	Y	N	
MAMMOGRAM		Y	N	INFLUENZA	Y	N	
PSA LEVEL		Y	N	MENINGITIS	Y	N	
DIABETES SCREENING		Y	N	PNEUMONIA	Y	N	
CHOLESTEROL TESTING		Y	N	SHINGLES	Y	N	
EKG OR STRESS TEST		Y	N	HPV	Y	N	
CHEST XRAY		Y	N	HEP B	Y	N	

MEDICATIONS-PRESCRIBED & OVER THE COUNTER

MEDICATION	DOSE

PHARMACY:________________

Pt # ____________

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RELEASE OF INFORMATION

Patient Name: ______________________________ Date of Birth: _____/_____/_______

I. Authorization for ______________________________ to disclose my health care information.
(name of facility)

(City) ________________________ (State)______

II. You may disclose the following health care information:

____

III. You may disclose this health information to:

Name/title and organization: **DELHI RURAL HEALTH CLINIC ~ PHYSCIAN:**______________

Address: **508 BROADWAY ST., DELHI, LA. 71232**

IV. Purpose of this authorization: ____At my request _____Other:____________________

V. This authorization ends: ____on date ___/___/_____

____When the following event occurs____________________

VI. My Rights;

- I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment enrollment, or eligibility). (45 CFR 164.508 (b)(5) and 164.508 (c)(2))
- I may revoke the authorization in writing by sending a letter to the health care provider to whom the authorization is directed. If I did, it would not affect any actions already taken by the health care provider based upon the authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. (45 CFR 164.508 (b)(5) and 164.508 (c)(2))
- I understand that once the health care provider discloses my health information, the person or entity that receives it, may re-disclose it. The HIPAA Privacy laws may no longer protect it. (45 CFR 164.508 (c)(2))
- I understand that this authorization is for the release of medical records only and does not authorize verbal communications by the health care provider to the person or entity to whom the records may be released. (La. Code Cov. Proc. Art 1465.1)

______________________________________ Date: ____/____/______
Patient

______________________________________ ______________________________
Individual legally authorized to sign on behalf of patient Representative's authority to act for patient