HINTON HEALTH RIGHT

209 Temple Street
Hinton, WV 25951
304-466-9222
Fax: 304-466-9224

You will nedd to fill out the 4 page application and return it to the clinic along with:

PHOTO ID
PROOF OF INCOME
INSURANCE CARD

HINTON HEALTH RIGHT
2022 PATIENT REGISTRATION FORM

PATIENT NAME: _____ DATE OF BIRTH _____
LAST FIRST MI

MAILING ADDRESS: _____ SOCIAL SECURITY # _____

EMPLOYED: YES NO

WHERE EMPLOYED: _____

CITY: STATE: ZIP CODE: WORK PHONE# _____

PHONE#:

HOME: CELL:

DRUG ALLERGIES: _____

E-MAIL ADDRESS

EMERGENCY CONTACT INFORMATION

ALLERGIC REACTION: _____

NAME: _____

PHONE # _____

HAVE YOU APPLIED FOR MEDICAID YES

IF YES, WHAT MONTH & YEAR _____

RELATIONSHIP _____

ARE YOU ENROLLED IN MEDICARE YES

ARE YOU A VETERAN YES

MARITAL STATUS	SEX	RACE	HOMELESS STATUS	MEDICAL INSURANCE
☐ MARRIED	☐ FEMALE	☐ WHITE	☐ NOT HOMELESS	☐ NO INSURANCE
☐ SINGLE	☐ MALE	☐ BLACK	☐ SHELTER	☐ MEDICARE A B
☐ WIDOWED		☐ ASIAN	☐ STREET	☐ MEDICAID
☐ DIVORCED		☐ HISPANIC	☐ LIVING WITH FRIEND	☐
☐ SEPERATED		☐ INDIAN	OR RELATIVE	☐ VETERANS
		☐ OTHER		☐ PRIVATE INS

DO YOU HAVE A REGULAR DOCTOR YES NO

IF YES, WHO

DATE OF LAST VISIT

NUMBER OF PEOPLE IN HOUSEHOLD

HAVE YOU BEEN TO AN ER IN THE PAST YEAR YES

IF YES, NAME OF HOSPITAL OR ER

IF YES, NUMBER OF VISITS TO THE ER

IN AN EMERGENCY WHICH HOSPITAL WOULD YOU USE?

LIST FULL NAME & AGE OF ALL HOUSEHOLD MEMBERS **CIRCLE TYPE OF INCOME**

NAME	AGE	WAGES	SOC.SEC/ DISABILITY	RETIREMENT	WORKERS COMP/ UNEMPLOYMENT	FOOD STAMP ALIMONY/CHILD SPT	TOTAL

PATIENT AGREEMENT/DISCLOSURE

I agree to allow Beckley Health Right Inc. to complete any patient assistance program enrollment processes on my behalf, which may include disclosure of personal & medical information, soft credit check and other information necessary to determine eligibility for available drug manufacturer programs to secure my prescribed medication. Your information is confidential and secure, and only available to licensed prescribers, Beckley Health Right pharmacy and Administrative staff. By signing this form, I attest that this information is true and accurate. I also agree that if I enroll with any medical insurer (including but not limited to Medicaid & Medicare programs) of if my financial situation changes that I will immediately notify Beckley Health Right Inc. I also agree to allow pharmaceutical company auditors to review my information as needed for participation in patient assistance programs.

PATIENT SIGNATURE _____ DATE _____

CLINIC USE ONLY **CLINIC USE ONLY**

Form complete	Initials		Tax return	Initials	
Photo ID	Initials		HIPAA form	Initials	
POI	Initials		0 Income form	Initials	

HINTON HEALTH RIGHT

"BECAUSE WE CARE"

CONSENT FOR TREATMENT

PATIENT NAME _____ DATE OF BIRTH _____

GENERAL CONSENT FOR TREATMENT

I request and authorize health care services by my provider and his/her designee(s) as my provider may deem advisable and in my best intrest. This may include routine diagnostic, radiology and laboratory procedures and medication administration

I understand that excluding emergency circumstances, no substantial procedure will be performed without providing me an opportunity to give informed consent for that procedure.

RELEASE OF MEDICAL INFORMATION

This form has been fully explained to me, and I understand it's content and significance. I consent to Beckley Health Right, inc. to use my health informationrelated to the medical services provided for the following purposes: my treatment, obtaining payment for the medical services and for health care operations of Beckley Health Right, Inc. or other treating providers all as permitted under federal and state law regulations.

_____ _____

Signature of Patient Date

_____ _____

Signature of legal representative (if patient is unable to sign) Relationship to patient

PATIENT INTAKE QUESTIONNAIRE

NAME: **DATE OF BIRTH:**

Personal habits: Do you have any of the following habits:

Yes	No	Smoke tobacco? If yes, how may packes per day?		Age started?	
Yes	No	Chew tobacco? If yes, what type?	How much?		Desire to quit?
Yes	No	Body Piercing? If yes, where?		How many?	
Yes	No	Have tattoos? If yes, where?		Done by professional or friend?	
Yes	No	"Shot up" drugs, If yes, when was the last time?		Which drug?	
Yes	No	Used other drugs? If yes, when was last time?		Which drug?	
Yes	No	Drink alcohol? If yes, how much?		How often?	
Yes	No	Told you could NOT give blood or plasma? If yes, When?		Why?	

Your Medical History: I have problems with my health in the following ways (check all that apply)

	Anxiety		Depression		Drug dependence
	High blood pressure		Heart Attack		Blood clots
	Asthma		Epilepsy or seizures		Emphysema/COPD
	Pneumonia		Migraines		Hepatitis (sore liver)
	Stomach/Heartburn		Rectal bleeding		Diabetes (type)
	Cancer (where)		Bone problems		Skin infections
	Gum/Tooth decay		Eye problems		Hearing problems
	Sexual problems		Bladder infections		Kidney stones/infections
	Breast Lump		Testicular lump		Blood transfusions (year)
	Pain		Thyroid		Other:

WOMEN ONLY

Could you be pregnant?	Y	N			Are you menopausal?	Y	N
Do you use birth control	Y	N	What type?		Do you self breast exam?	Y	N
Date of last PAP test					Date of last mammogram		
Date of last menstrual cycle started					How many pregnancies?		
Number of live births?			Vaginal birth	Y N	C-section?	Y	N

FAMILY HISTORY: (who in your family has had the following health problem?) check all that apply

Specify family member - M=Mother, F=Father, GM=Grandmother, GF=Grandfather

Substance Abuse?	Kidney problems?
Alcohol/Drugs	Asthma?
Cancer? (what type)	Migraines?
Diabetes?	Depression/Nerves?
Heart problems?	Seizures/Fits
Heart attack?	Thyroid Disease?
High blood pressure	Bleeding Disease?

PATIENT INTAKE QUESTIONNAIRE (Continued)

NAME: **DATE OF BIRTH:**

PREFERRED PHARMACY?

Prescription medication you are currently taking

Medication name	Dosage	How often taken	Last time taken

Over the counter medications and home remedies currently used?

Medication name	Dosage	How often taken?	Last time taken

Hospitalization and Surgery: (within last 6 months)

Date	Reason

Recent radiology tests/labs (within last 6 months)

Date	Reason

I give my permission to be examined and treated by Beckley Health Right provides and agree to do my part to follow the medical plan recommended to me by the Beckley Health Right Staff.

Patient signature Date