

BECKLEY HEALTH RIGHT

**111 RANDOLPH STREET
Beckley, WV 25801
304-253-3577 or 304-253-4600
Fax: 304-253-3500**

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

**PHOTO ID
PROOF OF INCOME
INSURANCE CARD**

BECKLEY HEALTH RIGHT 2023 PATIENT REGISTRATION FORM

PATIENT NAME: LAST _____ FIRST _____ MI _____ MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ PHONE#: _____ HOME: _____ CELL: _____ E-MAIL ADDRESS _____ EMERGENCY CONTACT INFORMATION NAME: _____ PHONE # _____ RELATIONSHIP _____	DATE OF BIRTH _____ SOCIAL SECURITY # _____ EMPLOYED: YES _____ NO _____ WHERE EMPLOYED: _____ WORK PHONE# _____ DRUG ALLERGIES: _____ ALLERGIC REACTION: _____ HAVE YOU APPLIED FOR MEDICAID YES _____ IF YES, WHAT MONTH & YEAR _____ ARE YOU ENROLLED IN MEDICARE YES _____ ARE YOU A VETERAN YES _____
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MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPERATED	SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	RACE <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> ASIAN <input type="checkbox"/> HISPANIC <input type="checkbox"/> INDIAN <input type="checkbox"/> OTHER	HOMELESS STATUS <input type="checkbox"/> NOT HOMELESS <input type="checkbox"/> SHELTER <input type="checkbox"/> STREET <input type="checkbox"/> LIVING WITH FRIEND OR RELATIVE	MEDICAL INSURANCE <input type="checkbox"/> NO INSURANCE <input type="checkbox"/> MEDICARE A B <input type="checkbox"/> MEDICAID <input type="checkbox"/> VETERANS <input type="checkbox"/> PRIVATE INS
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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? _____
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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) or 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
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CLINIC USE ONLY	CLINIC USE ONLY
Form complete _____ Initials _____	Tax return _____ Initials _____
Photo ID _____ Initials _____	HIPAA form _____ Initials _____
POI _____ Initials _____	0 Income form _____ Initials _____

BECKLEY 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 interest. 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 its content and significance. I consent to Beckley Health Right, inc. to use my health information related 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 many packs 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