Mitchell Clinic, Ltd.

818 W HAVENS MITCHELL, SD 57301
PHONE (605)996-7526 FAX (605)996-1808
www.mitchellclinic.ltd

PLEASE USE LEGAL NAME, NO NICKNAMES

PATIENT'S FIRST NAME | MI | LAST

DATE OF BIRTH | MAILING ADDRESS WITH APT # IF APPLICABLE | CITY, STATE, ZIP

SOCIAL SECURITY # | SEX | *PREFERRED PHONE*__________ ☐ HOME ☐CELL ☐WORK

SPOUSE__________DOB__________

*ALTERNATE PHONE*__________ ☐HOME ☐CELL ☐WORK

PREFERRED PHONE__________
☐ HOME ☐CELL ☐WORK

There may be times our office needs to contact you to discuss your care.
I give permission to contact me by phone at ☐HOME ☐CELL ☐WORK
I give permission for Mitchell Clinic, Ltd. personnel to leave messages regarding appointments, treatment, etc., and to release verbal information as described above. Messages may be left on my phone at ☐HOME ☐CELL ☐WORK

MARITAL STATUS M D S W

PATIENT EMPLOYER

EMERGENCY CONTACT AND PHONE

IF PATIENT IS A MINOR, PLEASE COMPLETE

MOTHER'S NAME__________DOB__________ADDRESS__________

FATHER'S NAME__________DOB__________ ADDRESS

PERSON/GUARANTOR RESPONSIBLE FOR PAYMENT OF SERVICES(IF DIFFERENT FROM PATIENT)

Guarantor: Is your address the same as the Patient/Minor's address? ☐YES ☐NO (if no, provide information below)

NAME OF GUARANTOR__________PHONE__________

MAILING ADDRESS__________(Apt)__________City__________State__________Zip__________

All patients are expected to pay their insurance co-pay to Mitchell Clinic, Ltd. upon registration for every visit. A co-pay is an agreement between the patient and their insurance company and between the insurance company and Mitchell Clinic, Ltd.

PRIMARY INSURANCE	*SECONDARY INSURANCE*
INSURANCE NAME__________	INSURANCE NAME__________
CLAIMS ADDRESS__________	CLAIMS ADDRESS__________
SUBSCRIBER__________	SUBSCRIBER__________
RELATION TO PATIENT__________ ☐FAMILY COVERAGE	RELATION TO PATIENT__________ ☐FAMILY COVERAGE
ID__________GROUP__________	ID__________GROUP__________
EFFECTIVE DATE__________	EFFECTIVE DATE__________

AUTHORIZATION FOR TREATMENT: Realizing that I require medical care, I do hereby voluntarily consent to such medical care encompassing such diagnostic procedures and medical treatment by my provider, his\her assistants, or designees including consulting providers, employees and students in educational programs affiliated with Mitchell Clinic, Ltd., as is necessary in the judgment of my provider. I consent to testing for HIV(AIDS) and/or Hepatitis should a healthcare worker have accidental exposure to my blood or other body substances.

RELEASE OF INFORMATION: I hereby authorize Mitchell Clinic, Ltd. to release diagnostic and procedural information for the completion of insurance claim forms. I hereby authorize the release of clinical information to third party payers and\or their reviewing contractors to comply with preadmission review and continued stays requirements. I authorize the release of clinical information to referring physicians and facilities for the purpose of continued health care.

ASSIGNMENT OF BENEFITS: Authorization is hereby granted for the direct payment to Mitchell Clinic, Ltd. for all benefits payable to me. I understand I am financially responsible for all charges regardless of insurance coverage.

PATIENT SIGNATURE__________ DATE__________

PATIENT REPRESENTATIVE__________ RELATIONSHIP TO PATIENT__________

New Patient Information:

1. **Where have you been receiving medical care?**

2. **Why are you seeking to change?**

3. **Which doctor would you like to see?**

4. **What is your current health need?**

5. **How did you hear about us? (please circle one)**

   - **Family/Friend**
   - **Website**
   - **Facebook page**
   - **Physician referral**
   - **Newspaper**
   - **Other ________________________**

PATIENT HISTORY QUESTIONNAIRE MITCHELL CLINIC, LTD.

Name	age	sex M F	birth date

1. What type of work do you do?	marital status (please circle) married single divorced widowed

2. What other types of work have you done?

3. Have you ever lived overseas? If so where?

4. Tobacco usage	yes	no	amount per day	# of years	Beverage consumption	yes	no	amount per day
Cigarettes					Alcoholic beverages			
Cigar					Coffee or tea			
Pipe / chew					Caffiene containing soda pop			
If not, have you ever smoked?					When did you stop smoking?			

What drugs or medicines do you take regularly? (These include medicines that were prescribed by a physician and also medicines or vitamins that you can buy yourself without a prescription)	Name of prescription medicine	Amount per day	Name of nonprescription medicine or drug	Amount per day
	1.		1.	
	2.		2.	
	3.		3.	
	4.		4.	
	5.		5.	
	6.		6.	
	7.		7.	

What foods or medicines are you allergic to?	1.	2.	3.
	4.	5.	6.

What surgeries have you had?	Type	Hospital	Date
	1.		
	2.		
	3.		
	4.		
	5.		
	6.		

What other hospitalizations have you had?	Reason for hospitalization	Hospital	Date
	1.		
	2.		
	3.		
	4.		
	5.		
	6.		

FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH (list any medical problems)	IF DEAD, CAUSE OF DEATH (be specific)	Age at Death
FATHER				
MOTHER				
B S				
B S				
B S				
B S				
B S				
B S				

IS THERE A HISTORY OF ANY OF THE FOLLOWING IN YOUR FAMILY?

	YES	NO		YES	NO		YES	NO
TB			HEART DISEASE			INSANITY OR IDIOCY		
DIABETES			SKIN DISEASE			CANCER		
KIDNEY DISEASE			BLOOD DISEASE			FREE BLEEDING IN FAMILY		

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD:

	YES	NO		YES	NO		YES	NO
A STROKE			HIGH BLOOD PRESSURE			ANEMIA		
MIGRAINE HEADACHES			STOMACH OR DUODENAL ULCER			GOUT		
A SEIZURE			GALLSTONES			DIABETES		
THYROID PROBLEMS			YELLOW JAUNDICE			ARTHRITIS		
ASTHMA			PANCREATITIS			BLEEDING DISORDER		
EMPHYSEMA			KIDNEY STONE			CANCER (state type)		
TUBERCULOSIS			KIDNEY INFECTION					
HEART ATTACK			BLADDER INFECTION			MENTAL ILLNESS		
HEART FAILURE			PROSTATE PROBLEM					
HEART MURMUR			VENEREAL DISEASE (state type)					
RHEUMATIC FEVER								

Please list other problems not specified above.

Please list broken bones or injuries which required a physicians care (give dates)		TODAYS DATE

THIS SECTION FOR WOMEN ONLY

Age at onset of menstruation	When was your last normal period?	Number of pregnancies
Number of living children	Number of stillborn or miscarriages	

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AUTHORIZATION TO DISCUSS TREATMENT

There may be occasions when you want to give another person the ability to discuss your care at Mitchell Clinic, Ltd. (billing, treatment, appointments, prescriptions,etc.). Examples include spouse, parent (if you are over 18), another family member, coach, nursing home staff, care provider, etc. This authorization will allow discussion only. It does not authorize the release of medical records. I give my permission for Mitchell Clinic, Ltd. personnel to share information verbally regarding my treatment at Mitchell Clinic, Ltd. with the following person(s):

NAME:________________________ RELATIONSHIP____________________PHONE______________

NAME:________________________ RELATIONSHIP____________________PHONE______________

NAME:________________________ RELATIONSHIP____________________PHONE______________

The above authorization will expire on______________________________.

Do you have a durable power of attorney for healthcare? ☐YES ☐NO
IF YES, PLEASE PROVIDE A COPY TO THE OFFICE FOR YOUR MEDICAL RECORD

I acknowledge that the Notice of Privacy Practices is available upon request. Mitchell Clinic, Ltd. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Mitchell Clinic, Ltd., 818 W Havens, Mitchell, SD 57301.

PATIENT SIGNATURE________________________________

PATIENT REPRESENTATIVE____________________________

RELATIONSHIP TO PATIENT___________________________

DATE____________________