THE HEALTH HUT

REGISTRATION FORM

Date_____

Name: _____
FIRST MIDDLE INITIAL LAST

Address: _____ City: _____ State: ____ Zip: _____

Phone: Home (_____) _____ Work (_____) _____ Cell (_____) _____

Date of Birth: _____/_____/_____ Sex: ☐ M ☐ F Social Security #: _____-_____-_____

Marital Status: ☐ Single ☐ Married ☐ Other Email: _____

Do you consider yourself to be Hispanic or Latino (a person of Mexican, Puerto Rican, Cuban, Central American, South American, or other Spanish culture or origin, regardless of race)? ☐ Yes ☐ No

Race (Check one or more boxes.):
☐ White/Caucasian ☐ Black or African American ☐ North, South, or Central American Indian or Alaska Native
☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other: _____

Primary language: ☐ English ☐ Spanish ☐ Other: _____ Do you require a translator? ☐ Yes ☐ No

Are you employed? ☐ Yes ☐ No ☐ Retired ☐ Full-time ☐ Part-time Are you a student: ☐ Yes ☐ No

Name of Employer or School: _____

Do you have any health insurance, Medicaid, or Medicare? ☐ Yes ☐ No Please give card to receptionist.

What is your preferred location to be seen?
☐ Ruston (Monday & Friday) ☐ Grambling (Tuesday) ☐ Dubach (Wednesday) ☐ Simsboro (Thursday)
☐ Hispanic Clinic - Ruston (Tuesday & Thursday)

What pharmacy do you use? _____

Person to contact in case of emergency: _____

Phone: (_____) _____ Relationship to you: _____

THE HEALTH HUT

PATIENT DISCLOSURE

To qualify for services from The Health Hut, patients must meet the following guidelines. By checking the box below, you are stating that you meet this requirement. Meeting each requirement is required. Please complete and sign below.

- ☐ I am a resident of Lincoln Parish.
- ☐ I am 18 years of age or older.
- ☐ I do not have private health insurance or Medicare.

PATIENT AGREEMENT

As a patient,

- I understand that it is a privilege to be seen by The Health Hut.
- I understand that The Health Hut is open only at limited times, so I need to call for an appointment.
- I understand that the staff of The Health Hut can only see a certain number of patients per clinic.
- I understand that if I miss my appointment and do not call to cancel that I took up a slot in which someone else could have received medical care.
- I understand that The Health Hut can only serve eligible patients.

Therefore, as a patient I agree to:

- Treat all Health Hut staff and volunteers with the same respect and dignity that I expect to receive.
- Provide a 24-hour cancellation notice to (318) 513-1212 if I am unable to attend my scheduled appointment.
- Notify The Health Hut staff or volunteers of any changes to my address, residency or health insurance status.
- Notify The Health Hut staff or volunteers if I am currently enrolled or eligible for employer sponsored health insurance, Medicare/Medicaid or VA coverage.
- Comply with treatment instructions from The Health Hut medical staff and follow up with my Health Hut provider.

By signing below, I understand and agree to The Health Hut patient expectations. If I fail to uphold these expectations, I understand that my privileges as a patient may be changed or terminated.

_____ _____

Patient Signature Date

General Consent for Treatment, Tests and Services

I voluntarily consent to my treatment at The Health Hut and authorize examinations, blood tests (including blood tests for communicable disease such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my nurse practitioner, consulting physicians, fellows, residents, interns, and their associates and assistants or rendered by The Health Hut personnel under the instructions, orders or direction of such healthcare providers.

I acknowledge that this is not an urgent care facility.

I agree and understand that all health care providers involved in my care in any way are responsible and liable for their own acts and omissions, and The Health Hut is not responsible or liable for the acts or omissions of the aforementioned. I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care or examinations in The Health Hut. If I am uninsured, I understand that per Louisiana RS 9:2799.5, if I am injured in this clinic because of services provided or services failed to be provided, I do not have the same legal recourse I would have against other healthcare providers.

I hereby authorize the nurse practitioners, nurses and other medical care providers of The Health Hut to examine and/or treat me as described above. I understand that one or more physicians, fellows, residents and/or interns at The Health Hut may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding (1) which nurse practitioners, physicians and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment.

_____ _____

Signature of Patient or Personal Representative Authorized by Law | Date

_____ _____

Relationship (if signature is not of Patient) | Date

The Health Hut

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices and have therefore been advised of how the health information about me may be used and disclosed by The Health Hut and how I may obtain access to and control this information.

I understand that The Health Hut will use and disclose health information about me in the course of providing medical care to me. I understand that my health information may include information both created and received by The Health Hut, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar health-related information.

I understand that The Health Hut is permitted to use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to or consult and coordinate with other health care providers in the course of my treatment; and
- Perform various office, administrative and business functions that support The Health Hut's ability to provide me with appropriate care.

Who is it okay to discuss your health with?

- □ No one
- □ _____ Relationship _____ Phone No. _____
- □ _____ Relationship _____ Phone No. _____

Print Patient Name: _____ **Date:** _____

Signature of patient or legal representative: _____

If signed by legal representative, relationship to patient: _____

Signature of THH Staff Member: _____ **Date:** _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (*Please specify*) _____

Date: _____

Chart: _____

Name: _____ **Date of Birth:** _____

Age: _____ **Which Pharmacy do you use?** _____

Are you allergic to anything? _____

Purpose of your visit today:

_____

_____

_____

_____

Please answer the following questions as accurately as possible. If you do not understand the question, please ask for assistance or leave it blank until you speak to a Nurse.

Review Of Systems: Do you have any of the following?

Weight Changes	Yes	No	**Swollen lymph nodes**	Yes	No	**Rapid heart rate**	Yes	No
Swollen feet/ankles	Yes	No	**Headache**	Yes	No	**Depression/anxiety**	Yes	No
Seizures	Yes	No	**Bleeding/bruising**	Yes	No	**Burning with urination**	Yes	No
Abdominal pain	Yes	No	**Joint/muscle pain**	Yes	No	**Back pain**	Yes	No
Skin rash	Yes	No	**Chest pain**	Yes	No	**Chronic diarrhea**	Yes	No
Neck pain	Yes	No	**Chronic cough**	Yes	No	**Chronic headaches**	Yes	No

Past Medical History: Have you ever had the following?

Heart attack	Yes	No	**Cancer**	Yes	No	**Thyroid disorder**	Yes	No
High Blood Pressure	Yes	No	**High Cholesterol**	Yes	No	**Asthma**	Yes	No
Irregular Heartbeat	Yes	No	**Stomach Ulcers**	Yes	No	**Anemia**	Yes	No
Diabetes	Yes	No	**Arthritis**	Yes	No	**Tuberculosis**	Yes	No
Stroke	Yes	No	**Glaucoma**	Yes	No	**Heart Valve Problem**	Yes	No
Kidney Disease	Yes	No	**Depression/anxiety**	Yes	No	**Hepatitis B or C**	Yes	No
Clotting Problem	Yes	No	**Heart Disease**	Yes	No	**Chronic Infection**	Yes	No
Osteoporosis	Yes	No	**Lupus/RA**	Yes	No	**Sickle Cell Disease/Trait**	Yes	No
Post Menopausal	Yes	No	**COPD**	Yes	No	**Heart Failure**	Yes	No
Migraines	Yes	No	**Prostatitis**	Yes	No	**AIDS / HIV**	Yes	No

Please list any other medical problems or concerns below.

_____

_____

_____

_____

Are you seeing another physician for any reason? Yes No

If yes, please list name _____

Past Surgical History: Please list any previous surgeries or hospitalizations.

_____
_____
_____
_____
_____

Medication List: Please list all medications you are taking including over-the-counter medications.

Medication Name	Dosage	How Often

_____
_____
_____
_____
_____
_____
_____
_____

Family History: Has any blood relative ever had the following?

Heart attack	Yes	No	**Breast Cancer**	Yes	No	**Thyroid disorder**	Yes	No
High Blood Pressure	Yes	No	**High Cholesterol**	Yes	No	**Stroke**	Yes	No
Diabetes	Yes	No	**Tuberculosis**	Yes	No	**AIDS / HIV**	Yes	No
Kidney Disease	Yes	No	**Depression/anxiety**	Yes	No	**Hepatitis B or C**	Yes	No
Clotting Problem	Yes	No	**Heart Disease**	Yes	No	**Heart Failure**	Yes	No

Please answer the following to the best of your knowledge. If it does not apply, write N/A.

Date of last Pap smear _____
Date of last mammogram _____
Date of last colonoscopy _____

Date of last cycle _____
Stool card completed _____

Married _____ Single _____ Widowed _____ Divorced _____ Separated _____

Do you drink alcohol? Yes No
If so, what type? Wine Beer Mixed drink Hard liquor Other _____
How much? 1-5 6-12 13-24 More than 24 Other _____
How often? Daily Weekly Monthly Other _____

Do you smoke or use tobacco products? Current Past Never
If so, what type? _____
How much a day? _____

Do you use any of the following?

Methamphetamine	Current	Past	PCP	Current	Past
Cocaine	Current	Past	Opiates	Current	Past
Marijuana	Current	Past	Amphetamines	Current	Past

Are you currently sexually active? Yes No Never
Partner? Multiple Male Female Spouse Other_____