New Patient Registration Form

Name (first, last, middle initial): ________________________________ Maiden/Other Name: ______________________

Physical Address: ____________________________________ City: _______________ State: ________ Zip: _________

Mailing Address (if different): ___________________________ City: _______________ State: ________ Zip: _________

Home Phone: _____________________ Mobile: ___________________ Work: ____________________ Ext: _________

Email: ____ DOB: _______ SSN: ____________________

Sex: ☐ Male ☐ Female

Sex Assigned at Birth: ☐ Male ☐ Female

Sexual Orientation: ☐ Straight or Heterosexual ☐ Bisexual ☐ Don't Know ☐ Lesbian, Gay, or Homosexual ☐ Something Else

Gender Identity: ☐ Male ☐ Female ☐ Transgender Female ☐ Transgender Male ☐ Other

Preferred Pronoun: ☐ He ☐ She ☐ They ☐ We ☐ Other

Race: (Check all that apply) ☐ White ☐ Asian ☐ Native Hawaiian ☐ Black/African American ☐ American Indian / Alaska Native ☐ Other Pacific Islander

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Primary Language: ____________________________________ Do you need interpreter services? ☐ Yes ☐ No

Primary Pharmacy: ____________________________________ Secondary Pharmacy: _________________________

Insurance Information: *Please complete the following Insurance information and provide a copy of insurance card(s)*

Primary Medical Same as: [ ] Patient

Ins Company: ___________________________________

ID #: _______________________ Grp #: ______________

Policy Holder Name: ______________________________

DOB: _______________ SSN: ______________________

Primary Dental Same as: [ ] Patient

Ins Company: ___________________________________

ID #: _______________________ Grp #: ______________

Policy Holder Name: ______________________________

DOB: _______________ SSN: ______________________

Secondary Medical Same as: [ ] Patient

Ins Company: ___________________________________

ID #: _______________________ Grp #: ______________

Policy Holder Name: ______________________________

DOB: _______________ SSN: ______________________

Secondary Dental Same as: [ ] Patient

Ins Company: ___________________________________

ID #: _______________________ Grp #: ______________

Policy Holder Name: ______________________________

DOB: _______________ SSN: ______________________

New Patient Registration Form

☐ I have more than two medical insurance carrier

As a Health Center that receives Federal funding, we are required to collect this information. All answers are confidential.

Marital Status: ☐ Annulled ☐ Divorced ☐ Domestic Partner ☐ Legally Separated ☐ Married ☐ Never Married ☐ Widowed ☐ None

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired - Retirement Date: ________ ☐ Self Employed ☐ Active Military ☐ Student ☐ Not Employed

Population Characteristics:

☐ I am a migrant dairy worker
☐ I am a seasonal migrant worker (non-dairy)
☐ I currently rent or own my home (or live with parent/guardian)
☐ I currently live in a shelter
☐ I currently live in transitional housing
☐ I rely on relatives/friends for housing
☐ I currently live on the street
☐ I live in a hotel or camper
☐ I am a US veteran

Person financially responsible, if not the patient – e.g. Parent of a minor child:

Name: ________________________________ Address: ____

Phone: __________________________Home/Work: _____________________DOB: __________________________

Name of Person Completing This form (if other than patient): ____

☐ Check here if the person completing this form has legal authority to consent for treatment of the registrant (requires supporting documentation if other than parent of a minor)

Income Information: *Please circle the appropriate family size and corresponding household income range. All answers are confidential.*

Family Size	0-100%	101-150%	151-200%	Over 200%
	Household Income Range Based on Family Size			
1	$0 to $12,760	$12,761 to $19,140	$19,141 to $25,520	$25,521 & Over
2	$0 to $17,240	$17,241 to $25,860	$25,861 to $34,480	$34,481 & Over
3	$0 to $21,720	$21,721 to $32,580	$32,581 to $43,440	$43,441 & Over
4	$0 to $26,200	$26,201 to $39,300	$39,301 to $52,400	$52,401 & Over
5	$0 to $30,680	$30,681 to $46,020	$46,021 to $61,360	$61,361 & Over
6	$0 to $35,160	$35,161 to $52,740	$52,741 to $70,320	$70,321 & Over
7	$0 to $39,640	$39,641 to $59,460	$59,461 to $79,280	$79,281 & Over
8	$0 to $44,120	$44,121 to $66,180	$66,181 to $88,240	$88,241 & Over

Medical History Questionnaire

Name:______________________________________DOB: _____________Today's Date: ____________________

Height: ____________ Weight: ___________ Previous Primary Care Provider:______________________________

Other Care Team Provider (e.g. specialist, out of state providers etc.):____

Advanced Directive:	Yes	No	Don't Know
Do you have an Advanced Directive? *(if yes, please provide a copy)*	☐	☐	☐
Would you like the Health Center to assist you in developing your Advanced Directive?	☐	☐	☐

Please answer the following questions as best you can, your answers are confidential.

	Yes	No	Don't Know
Have there been any major changes to your health within the past year?	☐	☐	☐
If yes, please explain: ____			
Do you have any artificial joints, heart valves, implants, or prosthesis?	☐	☐	☐
Have you had surgery, x-ray treatment, or chemotherapy for a tumor, growth, or other condition?	☐	☐	☐
If yes, please explain: ____			
Females Only:			
Are you currently pregnant?	☐	☐	☐
If Yes, Due Date: ____			
Are you currently breast feeding?	☐	☐	

Health History: *Do you currently have, or have you had any of the following? (Check all that apply)*

☐ Addiction	☐ High Cholesterol
☐ Anxiety/Panic Disorder/ PTSD	☐ Seizures
☐ Arthritis	☐ Joint Problems
☐ Asthma or Shortness of Breath	☐ Hernia
☐ Back or Neck Problems	☐ Gynecological Problems
☐ Blood Disease or Anemia	☐ Hearing Loss/ Ringing in Ears
☐ Bowel Disease or Ulcers	☐ Heart Disease or Chest Pain
☐ Dizziness	☐ High Blood Pressure
☐ Fainting	☐ Prostate Trouble
☐ Headaches	☐ Liver Disease or Hepatitis
☐ Loss of Consciousness	☐ Neurological Problems
☐ Memory Loss	☐ Skin Disease
☐ Bronchitis or Chronic Cough	☐ Tuberculosis
☐ Cancer or Tumor Location: ______________	☐ Trouble Sleeping
☐ Depression	☐ Thyroid Problems
☐ Diabetes	☐ Other: ______________________
☐ Emphysema	☐ ______________________
☐ Fractures, Bone/Joint Deformities	☐ ______________________
☐ Gout	☐ ______________________
☐ Eye Trouble, Injury, or Blindness	☐ ______________________

Medical History Questionnaire

Name:____DOB: ______________Today's Date: ____________________

Health Screening: *Please note the date of your last screening/occurrence for the following:*

☐ Colonoscopy Date: ________________________ ☐ PSA ________________________________

☐ Mammogram Date: ________________________ ☐ Pap Smear ________________________________

Last Menstrual Period Date: ____

Surgical History:

Date: ______________ Surgery: ____

Date: ______________ Surgery: ____

Date: ______________ Surgery: ____

Date: ______________ Surgery: ____

Date: ______________ Surgery: ____

Family History: *Has anyone in your immediate history experienced the following?*

	Father	Mother	Sibling	Child	
Cancer or Tumor	☐	☐	☐	☐	☐ **I am adopted and do not know my family history**
Diabetes	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	
Heart Disease / Heart Attack	☐	☐	☐	☐	
Mental Health	☐	☐	☐	☐	
Substance Abuse	☐	☐	☐	☐	
Other: ____________________________	☐	☐	☐	☐	

☐ Father Deceased Date of Death: __________ Cause of Death: ________________________________

☐ Mother Deceased Date of Death: __________ Cause of Death: ________________________________

Social History *(Check all that apply)*

☐ Alcohol Use Amount: ____

☐ Drug Use

☐ Smoker

☐ Former Smoker Estimated Quit Date: ____

☐ Chewing Tobacco

☐ Abuse/Neglect

☐ Employed Occupation: ____

☐ Occupational Injury Details: ____

☐ Retired

☐ Living with Spouse

☐ Living Alone

Medical History Questionnaire

Name:____DOB: ______________Today's Date: ____________________

Allergies:

Medication Allergies / Reaction	Food, Environmental, Animal Allergies / Reaction

Current Medications:

Medication	Dosage	Frequency	Reason for Medication?

Immunizations:

	Yes	No	Don't Know
Date of Last Tetanus Shot: ____________________ If unknown, was it in the last 10 years?	☐	☐	☐
Have you ever received the pneumovax pneumonia vaccine?	☐	☐	☐

If yes, date vaccine received: ____________________

I understand that, to the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health or medications, I will inform my health care provider immediately. I hereby give my consent to treatment for myself, or the named patient (of whom I am the parent, legal guardian, or foster parent) to the Northern Tier Center for Health.

We set aside time just for you. If you're running late or must change an appointment, please call us as soon as possible. Arriving late may require your provider to reschedule your visit to allow enough time for your care. If you miss an appointment, you may have to wait for another opening. By calling us when you are unable to make your scheduled appointment, we are able to see other patients waiting for an appointment.

____ ________________________

Signature of Patient or Guardian Date

Protected Health Information Release Authorization

Full Name ____ DOB ________________________

This will authorize ____

To use or disclose my protected health information to: Northern Tier Center for Health (NOTCH)

Address: Attn: Fairfax Health Center, 1199 Main Street, Fairfax, VT 05454

Phone/Fax: P: 802-849-2844 F: 802-849-2644

as described below for the following purpose: ☐ Continuity of Care ☐ Other: ______________________

Specific Information to be sent:

☐ All Records OR ☐ Diagnostic Imaging Reports ☐ Lab Reports
☐ Dental Records ☐ Consult Notes
☐ Immunizations ☐ Office Notes
☐ Other: ____

Dates of care include: ____

Electronic Documentation Received on CD or DVD: Please send to Richford Health Center – Care Coordination Department 44 Main Street, Ste. 200, Richford, VT 05476

- I understand that this authorization may be revoked in writing at any time, although revocation will not be effective as the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
- I understand that information to be released may include treatment related to: mental health, behavioral health, HIV/AIDS.
- I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_______________________________________ ____________________

Signature of Individual or Representative Date

____

Authority or Relationship of Representative

EXPIRATION DATE: This authorization will expire on ________________________

(If no date or event is stated, expiration is one year from the date it was signed.)