



## 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  Lesbian, Gay, or Homosexual  
 Bisexual  Something Else  
 Don't Know

Gender Identity:  Male  Female  Transgender Male  
 Transgender Female  Other

Preferred Pronoun:  He  She  They  We  Other

Race:  White  Black/African American  
(Check all that apply)  Asian  American Indian / Alaska Native  
 Native Hawaiian  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.*

	0-100%	101-150%	151-200%	Over 200%
<b>Family Size</b>	<b>Household Income Range Based on Family Size</b>			
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.): \_\_\_\_\_

<b>Advanced Directive:</b>	Yes	No	Don't Know
Do you have an Advanced Directive? <i>(if yes, please provide a copy)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Would you like the Health Center to assist you in developing your Advanced Directive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Have there been any major changes to your health within the past year?  Yes  No  Don't Know

*If yes, please explain:* \_\_\_\_\_

Do you have any artificial joints, heart valves, implants, or prosthesis?  Yes  No  Don't Know

Have you had surgery, x-ray treatment, or chemotherapy for a tumor, growth, or other condition?  Yes  No  Don't Know

*If yes, please explain:* \_\_\_\_\_

**Females Only:**

Are you currently pregnant?  Yes  No  Don't Know

*If Yes, Due Date:* \_\_\_\_\_

Are you currently breast feeding?  Yes  No

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

- |  |  |
|--|--|
| <input type="checkbox"/> Addiction                         | <input type="checkbox"/> High Cholesterol              |
| <input type="checkbox"/> Anxiety/Panic Disorder/ PTSD      | <input type="checkbox"/> Seizures                      |
| <input type="checkbox"/> Arthritis                         | <input type="checkbox"/> Joint Problems                |
| <input type="checkbox"/> Asthma or Shortness of Breath     | <input type="checkbox"/> Hernia                        |
| <input type="checkbox"/> Back or Neck Problems             | <input type="checkbox"/> Gynecological Problems        |
| <input type="checkbox"/> Blood Disease or Anemia           | <input type="checkbox"/> Hearing Loss/ Ringing in Ears |
| <input type="checkbox"/> Bowel Disease or Ulcers           | <input type="checkbox"/> Heart Disease or Chest Pain   |
| <input type="checkbox"/> Dizziness                         | <input type="checkbox"/> High Blood Pressure           |
| <input type="checkbox"/> Fainting                          | <input type="checkbox"/> Prostate Trouble              |
| <input type="checkbox"/> Headaches                         | <input type="checkbox"/> Liver Disease or Hepatitis    |
| <input type="checkbox"/> Loss of Consciousness             | <input type="checkbox"/> Neurological Problems         |
| <input type="checkbox"/> Memory Loss                       | <input type="checkbox"/> Skin Disease                  |
| <input type="checkbox"/> Bronchitis or Chronic Cough       | <input type="checkbox"/> Tuberculosis                  |
| <input type="checkbox"/> Cancer or Tumor Location: _____   | <input type="checkbox"/> Trouble Sleeping              |
| <input type="checkbox"/> Depression                        | <input type="checkbox"/> Thyroid Problems              |
| <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Other: _____                  |
| <input type="checkbox"/> Emphysema                         | _____  |
| <input type="checkbox"/> Fractures, Bone/Joint Deformities | _____  |
| <input type="checkbox"/> Gout                              | _____  |
| <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> I am adopted and do not know my family history
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease / Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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:**

Date of Last Tetanus Shot: \_\_\_\_\_ If unknown, was it in the last 10 years?      Yes    No    Don't Know  
       

Have you ever received the pneumovax pneumonia vaccine?      Yes    No    Don't Know  
       

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: St. Albans Health Center, Doctors Office Commons, 3 Crest Road, St. Albans, VT 05478

Phone/Fax: P: 802-524-4554 F: 802-527-6792

as described below for the following purpose:  Continuity of Care  Other: \_\_\_\_\_

Specific Information to be sent:

- |                                      |    |   |  |
|--------------------------------------|----|---|--|
| <input type="checkbox"/> All Records | OR | <input type="checkbox"/> Diagnostic Imaging Reports | <input type="checkbox"/> Lab Reports   |
|                                      |    | <input type="checkbox"/> Dental Records             | <input type="checkbox"/> Consult Notes |
|                                      |    | <input type="checkbox"/> Immunizations              | <input type="checkbox"/> Office Notes  |
|                                      |    | <input type="checkbox"/> 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.)