



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%
Family Size	Household Income Range Based on Family Size			
1	\$0 to \$12,880	\$12,881 to \$19,320	\$19,321 to \$25,760	\$25,761 & Over
2	\$0 to \$17,420	\$17,421 to \$26,130	\$26,131 to \$34,840	\$34,841 & Over
3	\$0 to \$21,960	\$21,961 to \$32,940	\$32,941 to \$43,920	\$43,921 & Over
4	\$0 to \$26,500	\$26,501 to \$39,750	\$39,751 to \$53,000	\$53,001 & Over
5	\$0 to \$31,040	\$31,041 to \$46,560	\$46,561 to \$62,080	\$62,081 & Over
6	\$0 to \$35,580	\$35,581 to \$53,370	\$53,371 to \$71,160	\$71,161 & Over

7+ Add additional \$4,540 to each category



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? <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?

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:

- | | | | |
|--------------------------------------|----|---|--|
| <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.)