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: (Check all that apply) ☐ White ☐ Black/African American ☐ 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: ______________

NOTCH
Northern Tier Center for Health
Federally Qualified Health Center

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											

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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.			
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

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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

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Medicare Questionnaire

Name: ____________________ DOB: ______________ Age: ________ Medicare # ____________________

Medicare Regulations require that each patient have a completed development form on file with the provider of medical services. This form contains answers to specific questions that help Medicare determine the primary insurance. The following questions must be completed before a claim is submitted to Medicare.

Working Aged

Are you still working? ☐ Yes ☐ No

If ***YES***, Do you have insurance with your employer ☐ Yes ☐ No

Name of Employer: ____________________

# of Employees: ____________________

Are you Retired? ☐ Yes ☐ No Date Retired: ____________

Disability

Are you receiving Medicare Benefits due to disability? ☐ Yes ☐ No

Is your Spouse working? ☐ Yes ☐ No ☐ N/A

If ***YES***, what is your spouse's age? ____________

Are you covered under your spouse's insurance? ☐ Yes ☐ No

If ***YES***, Name of Spouse's Employer: ____________________

Telephone Number: ____________________

If ***NO,*** when did your spouse retire? ____________

Auto/Liability/Trauma

Was this illness/injury the result of any kind of accident? ☐ Yes ☐ No

If ***YES***, Date of Accident: ____________

Type of Accident? (Auto, Motorcycle, ATV, etc.): ____________________

How did the accident occur? ____________________

Have you filed or do you intend to file a liability claim or lawsuit against any part that caused the injury? ☐ Yes ☐ No

If ***YES***, Please provide the name, address, and phone number of the insurance company and person you feel is responsible ____________________

Workman's Comp or Black Lung Program

Were you injured on the job? ☐ Yes ☐ No

Are you covered by the Black Lung Program? ☐ Yes ☐ No

If ***YES*** to either question above, please complete the following:

What was the date of the accident? ____________

Where did the accident occur? ____________________

How did the accident occur? ____________________

Provide the name of the Workman's Comp or Black Lung Program ____________________

Who was your employer at the time of injury? ____________________

What is your insurance claim #? ____________________

Medicare Questionnaire and Claim Authorization

PUBLIC HEALTH (FEDERAL GRANT)

Have you ever received treatment that has been covered under a Federal grant? ☐ Yes ☐ No

RENAL

Have you ever had renal disease or been on kidney dialysis? ☐ Yes ☐ No

Are you currently receiving dialysis treatment? ☐ Yes ☐ No

If ***YES***, List date you started dialysis treatment: ______________________

List date of kidney transplant: ______________________ ☐ N/A

Is your dialysis being given in a hospital or at home? ☐ Hospital ☐ Home ☐ N/A

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND INFORMATION RELEASE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to The Richford Health Center, Inc. D.B.A NOTCH for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the CMS/HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Co-insurance and deductible are based on the charge determination of the Medicare Carrier.

______________________________ ______________________

Patient Signature Date Completed

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient
☐ Guardian or conservator of patient
☐ Spouse or person financially responsible (where information solely for purpose of processing application for dependent healthcare coverage)