



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: _____



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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.*

2022 Household Income Range Based on Family Size				
Family Size	0-100%	101-150%	151-200%	Over 200%
1	<input type="checkbox"/> \$0 to \$14,580	<input type="checkbox"/> \$14,581 to \$21,870	<input type="checkbox"/> \$21,871 to \$29,160	<input type="checkbox"/> \$29,161 & Over
2	<input type="checkbox"/> \$0 to \$19,720	<input type="checkbox"/> \$19,721 to \$29,580	<input type="checkbox"/> \$29,581 to \$39,440	<input type="checkbox"/> \$39,441 & Over
3	<input type="checkbox"/> \$0 to \$24,860	<input type="checkbox"/> \$24,861 to \$37,290	<input type="checkbox"/> \$37,291 to \$49,720	<input type="checkbox"/> \$49,721 & Over
4	<input type="checkbox"/> \$0 to \$30,000	<input type="checkbox"/> \$30,001 to \$45,000	<input type="checkbox"/> \$45,001 to \$60,000	<input type="checkbox"/> \$60,001 & Over
5	<input type="checkbox"/> \$0 to \$35,140	<input type="checkbox"/> \$35,141 to \$52,710	<input type="checkbox"/> \$52,711 to \$70,280	<input type="checkbox"/> \$70,281 & Over
6	<input type="checkbox"/> \$0 to \$40,280	<input type="checkbox"/> \$40,281 to \$60,420	<input type="checkbox"/> \$60,421 to \$80,560	<input type="checkbox"/> \$80,561 & Over
7+	Add additional \$4,540 to each category			



Protected Health Information Release Authorization and Consent

Patient's Full Name: _____ DOB: _____

This will authorize (Organization's Name): _____

Address: _____ Phone/Fax: _____

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

Address: _____

AND:

Name: _____ Phone/Fax: _____

Address: _____

As described below for the following purpose(s): 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: _____

Substance Use Disorder Treatment Records provided prior to 2022 (including Medication Assisted Treatment records)

Other (please specify): _____

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

By Signing below, I authorize release of records and 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.
- Information to be released may include treatment related to: substance use disorder treatment and diagnosis, mental health, behavioral health, HIV/AIDS.
- 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. *Substance use disorder treatment records prior to 2022 are prohibited from redisclosure.

This authorization will expire on: _____
(If no date or event is stated, expiration is one (1) year from date it was signed)

Signature of Individual or Representative

Date