NORTHERN TIER CENTER FOR HEALTH

NOTCH

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: _____ Carrier: _____ Work: _____

Email: _____ DOB: _____ SSN: _____

Legal Sex	Current Gender	Sexual Orientation	Gender Identity
☐ Male ☐ Female	☐ Male ☐ Female	☐ Straight or Heterosexual ☐ Bisexual ☐ Lesbian, Gay, or Homosexual ☐ Don't Know ☐ Something Else	☐ Male ☐ Female ☐ Transgender Male (Female-to-Male) ☐ Transgender Female (Male-to-Female) ☐ Other
Preferred Pronoun			
☐ He/him ☐ She/her ☐ They/them ☐ Other:			

RACE (Select all that apply)					
ASIAN	NATIVE HAWAIIAN OR PACIFIC ISLANDER	BLACK OR AFRICAN AMERICAN	AMERICAN INDIAN OR ALASKA NATIVE	WHITE	CHOOSE NOT TO DISCLOSE
☐ Chinese ☐ Vietnamese ☐ Asian India ☐ Korean ☐ Filipino ☐ Japanese ☐ Other Asian	☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan	☐ Black or African American	☐ American Indian or Alaska Native	☐ White	☐ Choose not to Disclose

ETHNICITY		
HISPANIC, LATINO/A, OR SPANISH ORIGIN	NOT HISPANIC, LATINO/A OR SPANISH ORIGIN	CHOOSE NOT TO DISCLOSE
☐ Mexican ☐ American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Hispanic, Latino/A, or Spanish Origin ☐ Another Hispanic, Latino/A, and Spanish Origin	☐ Not Hispanic, Latino/a or Spanish origin	☐ Choose not to disclose

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: _____

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

Name: _____ Address: _____

Phone: _____ Home/Work: _____ DOB: _____

Marital Status		Are you a U.S. Veteran?	Are you an Agricultural Worker?
☐ Annulled ☐ Domestic Partner ☐ Married ☐ Widowed	☐ Divorced ☐ Legally Separated ☐ Never Married	☐ Yes ☐ No	☐ No ☐ Migrant ☐ Seasonal

Employment Status		Housing Status
☐ Full Time ☐ Part Time	☐ Self-Employed ☐ Not Employee	Are you Homeless? ☐ Yes ☐ No If Homeless, are you: ☐ Doubling up (living with others) ☐ Staying in a Shelter ☐ On the Street ☐ Living in Transitional Housing
Student Status		
Are you a student? ☐ Yes ☐ No		

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 check the appropriate box next to family size and corresponding household income range on the table below. As a Health Center that receives Federal funding, we are required to collect this information. All answers are confidential.*

	0-100% Federal Poverty Level				101-150% Federal Poverty Level				151%-200% Federal Poverty Level				Over 200% Federal Poverty Level	
Family Size	**Household Income Range based on Family Size**													
1	$0	to	$15,650	☐	$15,651	to	$23,475	☐	$23,476	to	$31,300		$31,301	& over
2	$0	to	$21,150	☐	$21,151	to	$31,725	☐	$31,726	to	$42,300		$42,301	& over
3	$0	to	$26,650	☐	$26,651	to	$39,975	☐	$39,976	to	$53,300		$53,301	& over
4	$0	to	$31,320	☐	$31,321	to	$48,225	☐	$48,226	to	$64,300		$64,301	& over
5	$0	to	$36,700	☐	$36,701	to	$56,475	☐	$56,476	to	$75,300		$75,301	& over
6	$0	to	$42,080	☐	$42,081	to	$64,725	☐	$64,726	to	$86,300		$86,301	& over

**Add $5,500 per each additional over 6*

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Dental History Questionnaire - Adult

Name: _____ DOB: _____ Today's Date: _____

Please answer these questions as best you can. We want to know your special needs so we can give you the best care. Please check the answer that is right for you, "Yes," "No," "DK" (Don't Know.) Your answers are confidential and for our records only.

MEDICAL	Yes	No	DK
Have there been any major changes to your health within the past year?	☐	☐	☐
If yes, please explain: _____			
Are you under the care of a physician or are you receiving ongoing medical care?	☐	☐	☐
Name of your Physician: _____			
Phone Number: _____			
Date of your last medical visit: _____			
	Yes	**No**	**DK**
Are you Pregnant?	☐	☐	☐
If yes, due date: _____			
Do you breast feed?	☐	☐	☐
Do you have any artificial joints, heart valves, implants or prosthesis?	☐	☐	☐
Have you been told you need to be pre-medicated prior to dental treatment?	☐	☐	☐
Do you have any head, neck, or jaw problems?	☐	☐	☐
Do you have any teeth clenching or grinding?	☐	☐	☐
Do you have any pain in your teeth?	☐	☐	☐
Do you frequently bite your lips or cheeks?	☐	☐	☐
Have you had surgery, x-ray treatment, or chemotherapy for a tumor, growth or other condition?	☐	☐	☐
If yes, please explain: _____			

DENTAL	Yes	No	DK
Are you having any dental discomfort currently...	☐	☐	☐
Have you ever had serious trouble with previous dental work?	☐	☐	☐
If yes, please explain: _____			
Does dental work make you nervous?	☐	☐	☐
Have you ever had any abnormal bleeding associated with previous extractions, surgery, or trauma?	☐	☐	☐
If yes, please explain: _____			
Date of your last dental visit: _____			
Do your gums bleed when you brush your teeth?	☐	☐	☐
Do your gums bleed when you floss your teeth?	☐	☐	☐
Do you have a history of difficult extractions?	☐	☐	☐
Have you ever had orthodontic treatment?	☐	☐	☐
Do you use tobacco products?	☐	☐	☐
If yes, what and how much: _____			
Do you use alcohol?	☐	☐	☐
If yes, what and how much: _____			

Prescriptions and Over-the-Counter Medications: Do you take any of the following?

☐ Fosamax ☐ Actonel ☐ Aetna ☐ Boniva ☐ Prolia ☐ Aredia ☐ Zometa ☐ Xgeva ☐ Reclast

Please list all of the medications you are taking (please include prescription and non-prescription medications)

Medication	Dosage	How often	Reason

Allergies:

☐ Local anesthetics such as Novocain ☐ Barbiturates ☐ Sedatives ☐ Aspirin
☐ Penicillin ☐ Latex ☐ Peanuts ☐ Red Dye ☐ Sulfa Drugs
☐ Iodine ☐ Other: _____

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Dental History Questionnaire - Adult

MEDICAL INFORMATION: Please check the answer that is right for you, "Yes", "No", "DK" (Don't Know)

	Yes	No	DK
Stomach Problems	☐	☐	☐

	Yes	No	DK
Diabetes	☐	☐	☐
Thyroid Problems	☐	☐	☐
Other Gland problems	☐	☐	☐

Comments: _____

Breathing/Lung Problems	Yes	No	DK
Hay Fever	☐	☐	☐
Shortness of Breath	☐	☐	☐
Persistent Cough	☐	☐	☐
Positive Test, Treatment for Tuberculosis	☐	☐	☐
Seasonal Allergies	☐	☐	☐
Asthma	☐	☐	☐
Emphysema	☐	☐	☐
Coughing up blood	☐	☐	☐

Comments: _____

	Yes	No	DK
Skin Problems	☐	☐	☐

Heart and Circulatory Problems	Yes	No	DK
Heart Attack	☐	☐	☐
If yes, when?: _____			
High Blood Pressure	☐	☐	☐
Chest Pain (Angina)	☐	☐	☐
Heart Murmurs	☐	☐	☐
Artificial Valves	☐	☐	☐
Other Heart problems	☐	☐	☐

Comments: _____

Liver	Yes	No	DK
Hepatitis A, B or C	☐	☐	☐
Alcoholic Liver Disease	☐	☐	☐
Other Liver Disease	☐	☐	☐
Jaundice	☐	☐	☐

Comments: _____

Do you have any other disease, condition or problem not listed?

Please explain: _____

_____

_____

Blood Problems	Yes	No	DK
Bleeding Problems	☐	☐	☐
Anemia	☐	☐	☐
Hemophilia	☐	☐	☐
Are you taking Blood Thinners?	☐	☐	☐

What is your recent INR level? _____

Comments: _____

	Yes	No	DK
Neurologic Problems	☐	☐	☐

Comments: _____

Other	Yes	No	DK
Immune System Disorders	☐	☐	☐
Sexually Transmitted Disease	☐	☐	☐
AIDS/HIV	☐	☐	☐
Kidney or Bladder Problems	☐	☐	☐

Comments: _____

_____

_____

_____

_____

I understand that, to the best of my knowledge, all answers are true and correct. If I ever have any change in my health or medications, I will inform my health/Dental 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 Northern Tier Center for Health (NOTCH).

We set aside time just for you. If you're running late or need to change an appointment, please call us as soon as possible. If you arrive late to your appointment your provider might need to reschedule your visit. If you miss three appointments within 2 years you will be discharged from the practice

_____

Signature of Patient or Guardian **Date**

_____

Reviewed By **Date**

NORTHERN TIER CENTER FOR HEALTH
NOTCH

Protected Health Information Release Authorization and Consent

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____ Cell phone: _____

Information Requested From: _____ Email: _____

Address: _____ Phone/Fax: _____

Information Released To: Northern Tier Center for Health (NOTCH)

Address: Please Select a Clinic Phone/Fax: _____

As described below for the following purpose(s): ☐ Continuity of Care ☐ Other: _____

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

Other (please specify): _____

Dates of care include: _____

MEDENT Customers: *Please send by Direct N2N Message - Practice@notch.medentdirect.com*
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 if I do not state a date of expiration below, then this consent will expire one year from the last date of service to me at the Northern Tier Health Center (NOTCH). I understand that information released may include medical, psychiatric, mental health and/or drug and alcohol records. I understand that my Medical Records are protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by state and federal regulations. A photocopy or facsimile of this consent is valid as is the original. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes. You are authorizing the Northern Tier Center for Health (NOTCH) to disclose your records in the following formats: verbal, written, electronic, unless otherwise specified here.

This authorization will expire on: _____
(If no date or event is stated, this release will expire one (1) year from the last visit the patient had)

_____ _____
Patient Signature: Date

_____ _____
Guardian or Legal Representative Signature Date

I understand that I may revoke this consent at any time. My decision to revoke this consent will not affect the records that were previously released under this consent. I hereby revoke this consent on: _____ (date). Do not release any further information under this consent.
Signature: _____

NORTHERN TIER CENTER FOR HEALTH
FEDERALLY QUALIFIED HEALTH CENTER

Consent for Treatment, Payment, and Healthcare Operations

Patient Name: _____ **Date of Birth**: _____
Please Print Please Print

I. Consent for Treatment:

I hereby give my consent for treatment for myself, or the named patient (of whom I am the parent or legal guardian of and have the legal right to consent to treatment) to the Northern Tier Centers for Health (NOTCH). Treatment may include health screening, diagnosis, medical treatment, dental treatment, mental health, psychiatry services, and drug and alcohol screening, assessment, diagnosis, and treatment.

II. Consent to Release Health Information

I consent to the use within NOTCH and the disclosure to persons or organizations outside of NOTCH of my (or of the named patient for whom I am the parent or legal guardian) medical, dental, Care Quality Interoperative (HIE), Surescripts/Pharmacy, drug and alcohol, mental health, psychiatry and other treatment and health records ("health information") by NOTCH for the following purposes:

A. Use of health information by or for NOTCH for treatment, payment, and health care operations.

- Providing treatment by NOTCH staff
- Conducting health care operations, including financial or quality assurance audits and / or training.
- Prescription ordering/refilling
- Billing your insurance company directly
- Processing payment for healthcare services, including the disclosure of health records to insurance companies, workers' compensation or liability carriers, or other agencies responsible for payment. This may also include updating insurance information on file with NOTCH.

B. Disclosure of health information to people or organizations outside of NOTCH for treatment purposes:

- NOTCH is authorized to provide all past and present health information including 42 CFR. Part 2 document to other health care providers or agencies who participate in your care. This includes past medical records from outside organizations, prescriptions, drug and alcohol screening, diagnosis, and treatment.
- An individual release of information must be submitted for each transfer of care, family, friends, or other people that you wish to have access to your Medical Record information.

III. Assignment of Benefits

I authorize NOTCH to bill and receive payment directly from Medicare / Medicaid or any other insurance carrier for services provided to me.

I hereby assign to all payments from Medicaid, Medicare, or any health insurance policy for health care, rendered to be me by NOTCH.

I understand I am responsible for any unpaid balances incurred due to my care at NOTCH.

I understand that, to the best of my knowledge, the demographic information I provided is true and correct.

IV. Termination and restrictions of this consent:

A. I understand that I may revoke this consent at any time by providing written notice to NOTCH. Revocation will not affect any actions taken by NOTCH in reliance on this consent prior to the date of revocation. Unless otherwise revoked in writing, this consent will expire three (3) years after the date of my last service with NOTCH.

B. I understand that I may request restrictions on the use or disclosure of my health information for the purposes described in this consent and that NOTCH may or may not agree to the request. I also understand that except for those restrictions on use or disclosure of health information to which NOTCH agrees, NOTCH will not be able to provide services to me (or the named patient without this signed consent.

C. I have read this Consent for Treatment & Consent to the Release of Health Information; I understand and knowingly consent to its content.

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices and understand NOTCH will use my protected health information in accordance with privacy law.

Patient Signature: _____ Date: _____

Parental Signature: _____ Date: _____

Guardian Signature/ POA: _____ Date: _____

If you are a legal guardian/power of attorney of a patient, this document is not valid until legal paperwork is provided.