



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: _____

Sex
RACE (Select all that apply)
ETHNICITY

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: _____



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

Name: _____ Address: _____

Phone: _____ Home/Work: _____ DOB: _____

Emergency Contact: _____

Marital Status		Are you a U.S. Veteran?	Are you an Agricultural Worker?
<input type="checkbox"/> Annulled	<input type="checkbox"/> Divorced	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Legally Separated	<input type="checkbox"/> No	<input type="checkbox"/> Migratory
<input type="checkbox"/> Married	<input type="checkbox"/> Never Married		<input type="checkbox"/> Seasonal
<input type="checkbox"/> Widowed			
Employment Status		Housing Status	
<input type="checkbox"/> Full Time	<input type="checkbox"/> Self-Employed	Are you Homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Part Time	<input type="checkbox"/> Not Employed	If Homeless, are you:	
Student Status		<input type="checkbox"/> Doubling up (living with others)	
Are you a student?		<input type="checkbox"/> Staying in a Shelter	
<input type="checkbox"/> Yes		<input type="checkbox"/> On the Street	
<input type="checkbox"/> No		<input type="checkbox"/> Living in Transitional Housing	

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.

Family Size	0-100% Federal Poverty Level		101-150% Federal Poverty Level		151%-200% Federal Poverty Level		Over 200% Federal Poverty Level						
	Household Income Range based on Family Size												
1	\$0	to	\$15,960	\$15,961	to	\$23,940	\$23,941	to	\$31,920	\$31,921	& over		
2	\$0	to	\$21,640	\$21,641	to	\$32,460	\$32,461	to	\$43,280	\$43,281	& over		
3	\$0	to	\$27,320	\$27,321	to	\$40,980	\$40,981	to	\$54,640	\$54,641	& over		
4	\$0	to	\$33,000	\$33,001	to	\$49,500	\$49,501	to	\$66,000	\$66,001	& over		
5	\$0	to	\$38,680	\$38,681	to	\$58,020	\$58,021	to	\$77,360	\$77,361	& over		
6	\$0	to	\$44,360	\$44,361	to	\$66,540	\$66,541	to	\$88,720	\$88,721	& over		

*Add \$5,500 per additional over 6

Effective 1/13/2026



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)

Table with 4 columns: Medication, Dosage, How often, Reason

Allergies:

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



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: _____ 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: _____



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.