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: _____ 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 on the table below. All answers are confidential.*

	0-100%				101-150%				151%-200%				Over 200%	
Family Size	**Household Income Range based on Family Size**													
1	$0	to	$15,060		$15,061	to	$22,590		$22,591	to	$30,120		$30,121	& over
2	$0	to	$20,440		$20,441	to	$30,660		$30,661	to	$40,880		$40,881	& over
3	$0	to	$25,820		$25,821	to	$38,730		$38,731	to	$51,640		$51,641	& over
4	$0	to	$31,200		$31,201	to	$46,800		$46,801	to	$62,400		$62,401	& over
5	$0	to	$36,580		$36,581	to	$54,870		$54,871	to	$73,160		$73,161	& over
6	$0	to	$41,960		$41,961	to	$62,940		$62,941	to	$83,920		$83,921	& over

**Add $5,380 per each additional over 6*

NORTHERN TIER CENTER FOR HEALTH

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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: Please Select Clinic

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

_____

Authority or Relationship of Representative

NORTHERN TIER CENTER FOR HEALTH
NOTCH

Dental History Questionnaire - Adult

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

Primary Care Provider: _____ Phone: _____ Last Physical Exam: _____

Please list any medical treatment you are currently receiving for any reason: _____

Please list any previous hospitalization for surgical procedures or serious illness: _____

	Yes	No
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atevia, Boniva, Reclast, or Prolia etc.) for osteoporosis or Paget's disease?	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA etc.) for bone pain, hypercalcemia, skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer?	☐	☐

Please list any medications or nutritional supplements? (Prescribed, over the counter, or illicit) you may be taking:

Medication	Dose/Frequency	Reason	Medication	Dose/Frequency	Reason

	Yes	No
Do you use tobacco or smokeless tobacco?	☐	☐
Do you use alcohol?	☐	☐
Do you have a persistent cough or throat clearing not associated with known illness (lasting more than 3 weeks)?	☐	☐

Allergies: Are you allergic to or have you had any reactions to the following *(check all that apply)*:

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

Medical History: *Do you currently have, or have you ever had any of the following? (Check all that apply)*

☐ High or ☐ Low Blood Pressure ☐ Heart Disease ☐ Heart Attack
☐ Cardiac Pacemaker ☐ Heart Murmur ☐ Rheumatic Fever
☐ Artificial Heart Valve ☐ Angina ☐ Thyroid Problem
☐ Kidney Disease ☐ Hepatitis ☐ Jaundice
☐ Hay Fever / Allergies ☐ Asthma ☐ Tuberculosis
☐ COPD / Emphysema ☐ Anemia ☐ Swollen Ankles
☐ Joint Replacement / Implant ☐ Arthritis ☐ Diabetes
☐ Fainting / Seizures ☐ Epilepsy ☐ Frequently Tired
☐ AIDS or HIV Infection ☐ Glaucoma ☐ Stroke
☐ Sexually Transmitted Disease ☐ Cancer ☐ Recent Weight Loss
☐ Leukemia ☐ Liver Disease ☐ Stomach Troubles / Ulcers
☐ Behavioral/Psychiatric Problems ☐ Other: _____

NORTHERN TIER CENTER FOR HEALTH
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Dental History Questionnaire - Adult

Women Only – are you: *(Check all that apply)*:

☐ Pregnant, or may be pregnant ☐ Nursing ☐ On Birth control

Dental History: *Do you currently have, or have you had any of the following? (Check all that apply)*

☐ Bleeding gums when brushing / flossing
☐ Sensitive teeth (to sweet/sour liquids/foods)
☐ Pain in any of your teeth
☐ Any head, neck, or jaw injuries
☐ Teeth clenching or grinding
☐ Frequently biting of lips/cheeks
☐ History of any difficulty extractions
☐ Prolonged bleeding after extractions
☐ Orthodontic treatment (e.g. braces)
☐ Instructions on brushing and flossing
☐ Any jaw problems (e.g., clicking or pain – joint, ear, side of face etc.)
☐ Difficulties with any dental treatment

Explain: _____

_____

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

NORTHERN TIER CENTER FOR HEALTH
FEDERALLY QUALIFIED HEALTH CENTER

Consent to Treat

Patient Name: _____ Date of Birth: _____

I hereby give my consent to **Richford Health Center, Inc. dba Northern Tier Center for Health (NOTCH)** to administer medical/dental treatment, local anesthetics and to perform any diagnostic studies necessary.

For those healthcare providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those healthcare providers who have rendered services to me and who accept such assignment. I agree to pay all charges that are not paid in full by assigned insurance.

I hereby authorize Northern Tier Center for Health to obtain medication history, from community pharmacies and/or pharmacy benefit managers for the purpose of continued treatment.

NOTCH Is committed to protecting the confidentiality of patient health information (PHI) per Health Insurance Portability and Accountability Act (HIPAA) regulatory standards. NOTCH employees have a moral and professional obligation to respect confidentiality and protect the security of patient records, while limiting access to PHI to perform their assigned job duties as defined by HIPAA regulatory standards that fall under treatment, payment, and healthcare operations.

_____

Patient/Guardian/POA Signature Date

_____

Patient/Guardian/POA Name

Relationship:

☐ Patient

☐ Legal Guardian **Note this form is not valid until proof of legal guardianship is provided*

☐ POA for Healthcare **Note this form is not valid until proof of POA is provided*

If Legal Guardian / POA

☐ Proof of guardianship/POA for Healthcare received and uploaded to patient chart

☐ Proof of guardianship/POA for Healthcare is on file and was reviewed

Document upload/Review completed by _____ on _____

NORTHERN TIER CENTER FOR HEALT
FEDERALLY QUALIFIED HEALTH CENTER

Consent for Use and Disclosure of Health Information for Treatment, Payment, and Operations

Name: _____ DOB: _____ Date: _____

CONSENT FOR TREATMENT

I hereby give my consent to Richford Health Center, INC. dba Northern Tier Center for Health (NOTCH) to administer medical/dental treatment, local anesthetics and to perform and diagnostic laboratory studies necessary.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of our important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before singing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practice. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

AUTHORIZATION TO VERBALLY DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize physicians and staff of Richford Health Center, INC. dba Northern Tier Center for Health (NOTCH) to give verbal information about my (or the patient named below if I am the legal representative) appointments, medical care, test results and billing with the following persons:

Name	Phone Number	Relationship to Patient
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Release of infomration under this authorization is limited to verbal discussions. **This authorization does not permit release of any written health information to the individuals named above. This authorization does not provide the above-named person(s) with any authority, either implied or direct, over any treatment or direct care decisions.**

Right to Revoke: You will have the right to revoke this consent at any time by gibing us written notice of your revocation submitted to the health cater listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received you revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I understand that I may inspect or copy the protected health information described by this authorization. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I also authorize any institution, agency or person involved in my care to release my persona health information to the above indicated health center or dental clinic. The consent for authorization will expire and be renewed on the first service date of each calendar year.

_____ _____
Patient Name and DOB Patient Signature and Date

_____ _____
Signature of Representative and Date if Applicable Patient Signature and Date