Holyoke Health Center, Inc.

Affix label here

Last Name: _____ **First Name:** _____ **MI:** ___

Date of Birth: ___/___/___ **Date:** ___/___/___ **Medical Record #:** _____

REGISTRATION FORM

Welcome to Holyoke Health Center, Inc. We are glad that you have chosen us as your medical home. Please answer the following questions about yourself and your family so that we may be able to serve you. If you need help with any questions please ask and we will be glad to help you.

1. **Preferred Name (if different from legal name) :** _____ _____/_____/_____
   Social Security Number
2. **Health Care Proxy completed?** ☐ Yes ☐ No ☐ N/A
3. **Sex at birth:** ☐ Male ☐ Female
4. **Demographics:**

_____ _____
Mailing Street Address Apartment Number

_____ _____ _____
City State Zip

_____ _____ (_____)_____
Emergency Contact **(Relationship)** **Emergency Contact Phone Number**

_____ _____ (_____)_____
Parent / Guardian Printed Name (Relationship) Phone Number

_____ _____ (_____)_____
Parent / Guardian Printed Name (Relationship) Phone Number

_____ _____ ☐ Full Time ☐ Part Time ☐ Other (specify): _____
Employer Name Occupation

_____ ☐ Full Time ☐ Part Time ☐ Other (specify): _____
School Name

5. **Contact Methods:**

		Best Contact Method	Ok to leave a confidential message	
a.	**Daytime Phone:** (_____)_____	☐	☐ Yes	☐ No
b.	**Home Phone:** (_____)_____	☐	☐ Yes	☐ No
c.	**Cell Phone:** (_____)_____	☐	☐ Yes	☐ No

d. **Email Address:** _____

In order to serve you better, please answer the following questions.
(The information you give will be kept confidential and private. Information you share will not impact your eligibility for assistance, housing or other programs. You can still get services if you choose not to provide the following information).

6. **What is your current housing/homeless status?**
   - ☐ At a Shelter
   - ☐ Doubling Up with a friend/family member
   - ☐ In Transitional Housing
   - ☐ On the Street
   - ☐ Not Homeless
   - ☐ Decline to Specify

7. **What is your preferred spoken language?** _____

8. **What is your preferred written language?** _____

9. **Gender:**
   - ☐ Male
   - ☐ Female
   - ☐ Transgender Male ⇨ Female
   - ☐ Transgender Female ⇨ Male
   - ☐ Gender Queer
   - ☐ Decline to specify/ Other: _____

10. **Sexual Orientation:**
    - ☐ Straight (not lesbian or gay)
    - ☐ Lesbian or Gay
    - ☐ Bisexual
    - ☐ Something else
    - ☐ Don't Know
    - ☐ Decline to specify/ Other: _____

11. **What race(s) do you identify as?**
    - ☐ American Indian or Alaskan Native
    - ☐ Black or African American
    - ☐ White
    - ☐ Asian
    - ☐ Native Hawaiian or other Pacific Islander
    - ☐ Decline to specify

12. **What ethnicity do you identify as?**
    - ☐ Hispanic/ Latino
    - ☐ Non-Hispanic/ Latino
    - ☐ Decline to specify

13. **What is your household's total annual income?** _____

14. **How many people are in your household, including yourself?** _____

15. **Have you ever served in the military?** ☐ Yes ☐ No

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Last Name: _____ **First Name:** _____ **MI:** ___

Date of Birth: ___/___/___ **Date:** ___/___/___ **Medical Record #:** _____

16. Consent for Care/Treatment:

I hereby authorize the staff and supervised health professional students, of Holyoke Health Center, Inc. (HHC) to render such services as may be deemed necessary to me. I have read and understand my rights and responsibilities and I assign HHC authority to claim and collect medical insurance benefits and payments on my behalf. I understand that I am responsible for paying for my care if my insurance does not pay for it.

Signature: _____ Date: _____/_____/_____

In case of a minor child, signature is of:
☐ Parent ☐ Legal Guardian ☐ Emancipated Minor ☐ Power of Attorney

17. Notice of Privacy Practices:

I understand that Holyoke Health Center, Inc. (HHC) will use my health information for treatment, payment and healthcare operations. I have been given a copy of HHC's 'Notice of Privacy Practices', which provides a complete description of how my health information will be used. I understand that the organization reserves the right to change their notice and practices, and that I have the right to obtain a revised notice.

Signature: _____ Date: _____/_____/_____

In case of a minor child, signature is of:
☐ Parent ☐ Legal Guardian ☐ Emancipated Minor ☐ Power of Attorney

18. Additional person(s) authorized to make the use or disclosure PHI:

(Uses and disclosures may be permitted without prior consent in an emergency and according to our Notice of Privacy Practices.)

Holyoke Health Center, Inc. (HHC) values and does everything in our power to protect your privacy. Your medical information will not be given to any individual (including spouses, parents, children or any significant others without your written consent). If you would like for HHC to communicate with anyone other than yourself by phone, in person and may accompany any children into the office please list their name, date of birth and relationship below. A separate release of information is needed for anything other than communication with the following persons or anyone other than those listed. This includes any and all confidential information.

☐ **At this time I do not want to authorize anyone** (For children both parents will automatically have authorization unless court documents are presented stating one is not authorized.)

☐ **I, the undersigned, hereby authorize HHC staff to communicate with the following individual(s)**

a. Name: _____ Date of birth: _____ Relationship: _____

b. Name: _____ Date of birth: _____ Relationship: _____

Signature: _____ Date: _____/_____/_____

In case of a minor child, signature is of:
☐ Parent ☐ Legal Guardian ☐ Emancipated Minor ☐ Power of Attorney

HHC Staff: _____

Patient Medical History

Name: _____

DOB: _____

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you have or have you had any of the following?		
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments _____

_____

_____ Signature _____ Date _____

Building healthy communities
HOLYOKE HEALTH

Holyoke Health Center & Administrative Offices
230 Maple Street • P.O. Box 6260 • Holyoke, MA 01041-6260
P: 413-420-2220 • F: 413-420-2250 • TTY: 413-534-9472

Last Name: _____ First Name: _____

Date of Birth: ___/___/___ Date: ___/___/___ Medical Record#: _____

MEDICATION LIST

ALLERGIES:

MEDICATION & DOSE	WHEN TAKEN	PURPOSE

Chicopee Health Center: 505 Front Street • Chicopee, MA 01013
P: 413-420-2222 • F: 413-592-2324 • TTY: 413-534-9472

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Patient Responsibilities

The clinicians at Holyoke Health Center have the responsibility to provide you with the highest standard of care for your treatment.

You, the patient:

1. **Have the responsibility of notifying us of any change in your medical condition that will affect dental care.**
2. **Have the responsibility of keeping and being on time for your appointments. If you are more than 15 minutes late for an appointment, the doctor has the right to require you to reschedule your visit for another appointment, unless of course it is an emergency visit, where she will see you as soon as treatment time is available.**

Please comply with these conditions.

I, _____ fully understand my responsibility to notify Holyoke Health Center to changes in my medical condition and in making and keeping appointments.

Signature_____ **Date**_____

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P: 413-420-2222 • F: 413-592-2324 • TTY: 413-534-9472