Holyoke Health Center, Inc.

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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 so that we may be able to serve you. If you need help with any questions please ask.

1. **Preferred Name (if different from legal name) :** _____ _____/_____/_____
   Social Security Number

2. **Sex at birth:** ☐ Male ☐ Female **Health Care Proxy completed?** ☐ Yes ☐ No ☐ N/A

3. **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

4. **Contact Methods:** (It is important for us to have an active phone number for you so that we are able to contact you regarding appointments and anything pertinent to your health)

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

   (Cell phone numbers are an automatic OPT-IN for appointment reminders, notify the front desk if you would like to OPT-OUT of this option)

   d. Email Address: _____

5. **Insurance Information**
   Please inform the Front Desk staff if this visit is related to an Auto Accident, Workers Compensation, or Disability Claim

   Primary Insurance: _____ Policy#: _____
   Grp#: _____ Ins. Phone#: _____
   Insurance Address: _____
   Policy Holder's Name: _____ Relationship to Patient: _____
   Policy Holder's Birthdate: _____

*** If there is No** Secondary **Insurance, please circle: NONE**

Secondary Insurance: _____ Policy#: _____
Grp#: _____ Ins. Phone#: _____
Insurance Address: _____
Policy Holder's Name: _____ Relationship to Patient: _____
Policy Holder's Birthdate: _____

I have presented evidence of valid insurance coverage, as of this date below to Holyoke Health.
I understand that I am financially responsible for all charges incurred for services provided.
I understand that payment is due at the time of services are rendered.

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: (You do not have to answer for children under the age of 13)
- ☐ Male
- ☐ Female
- ☐ Transgender Male ⇨ Female
- ☐ Transgender Female ⇨ Male
- ☐ Gender Queer
- ☐ Choose not to disclose
- ☐ Other: _____

10. Sexual Orientation: (You do not have to answer for children under the age of 13)
- ☐ Straight (not lesbian or gay)
- ☐ Lesbian or Gay
- ☐ Bisexual
- ☐ Choose not to disclose
- ☐ Don't Know
- ☐ Something else: _____

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? _____

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

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. Process for Complaints and Grievances:

I understand that Holyoke Health Center, Inc. (HHC) wants to provide me with the best care possible. In the event that I am unhappy with services provided to me, I will let my provider know. I have been given a document describing how to file a complaint or grievance regarding any of the services I've received from the Holyoke Health Center, Inc.

Signature: _____ Date: _____/_____/_____

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

19. 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: _____

Building healthy communities
HOLYOKE HEALTH
Holyoke Health Center, Inc.
230 Maple Street ❖ P.O. Box 6260
Holyoke, MA 01041-6260
PHONE: 413-420-2200 ❖ TTY: 413-534-9472 FAX: 413-420-2280

We are required by law to obtain your written permission to release or obtain your medical/dental information

Patient's Information

Patient's Name _____ Patient's Date of Birth ___/___/_____
Last First Middle

Other name(s) used as a patient here: _____

Telephone: (____) _____ - _____ Email: _____

Address _____ City _____ State _____ Zip _____

☐ I authorize the Holyoke Health Center Inc., to **RELEASE** the indicated portions of my medical/dental records to the following Provider or facility:

☐ I authorize the Holyoke Health Center Inc., to **OBTAIN** the indicated portions of my medical/dental records from the following Provider or facility:

(Name and/or Facility): _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: (____) _____ - _____ Fax: (____) _____ - _____

Reason for Request:

☐ Personal use ☐ Transfer of care ☐ Referral/Specialist ☐ Legal Matter ☐ Employment

☐ Government related ☐ Other: _____

Indicate the <u>medical/dental documents</u> you agree to have released by checking the box and <u>initialing</u> below:

☐ _____ Recent Physical exam only ☐ _____ Immunizations only

☐ _____ Recent Lab Results only ☐ _____ Other: (specify)_____

☐ _____ **Full Medical Record**

☐ _____ Dental **Record** Only ☐ _____ Dental **X-rays** Only ☐ _____ Dental **Record with X-rays**

Date Range of Services: Form _____/_____/_____ to _____/_____/_____ or ☐ <u>All</u> Dates of Service

I understand that if my record has any of the following information it CANNOT be released. Indicate any **additional information** that you agree to be released by checking the box and **initialing** below. ***These documents will not be released without your consent!***

- ☐ ___ Alcohol or Drug Abuse Treatment *****
- ☐ ___ Sexually Transmitted Diseases
- ☐ ___ Genetic Information
- ☐ ___ HIV/AIDS Counseling/Treatment
- ☐ ___ Domestic Violence Counseling/ Treatment
- ☐ ___ Sexual Assault Counseling/ Treatment
- ☐ ___ Behavioral Health/Psychotherapy
- ☐ ___ Other: _____

***Protected by Federal Confidentiality Rules 42 CFR Part 2** (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2)

DELIVERY METHODS – Please deliver my records:

☐ As a paper printout ☐ By regular mail ☐ On a USB drive ☐ By Fax: **( ) _____ - _____**

If you are sending information to Holyoke Health Center Inc., please send to the following facility:

☐ **Holyoke Health Center**
230 Maple St
Holyoke, MA 01040
P: (413)420-2200
Medical Fax:
(413)420-2280
Dental Fax:
(413)420-2250

☐ **Chicopee Health Center**
505 Front St
Chicopee, MA 01013
P: (413)420-2222
Medical Fax:
(413)592-3382
Dental Fax:
(413)592-2324

☐ **Holyoke Health Dental Clinic**
Holyoke Soldiers Home
110 Cherry St
Holyoke, MA 01040
P: (413)420-6270
F: (413)536-6272

☐ **Holyoke Health Dental Clinic**
Western Massachusetts Hospital
91 East Mountain Rd
Westfield, MA 01085
P: (413)420-6260
F: (413)562-3380

Individual Rights: I understand and agree that:

- I may refuse to sign this authorization.
- I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing by sending written notification to the Privacy Officer at 230 Maple St. Holyoke, MA 01040.
- My right to revoke does not apply to information that has already been sent in response to this request.
- My treatment is not conditional upon this authorization.
- I have the right to inspect or obtain a copy of this medical/dental record as stated in federal privacy regulation CFR 164.524
- I understand that information used or disclosed because of this authorization may be disclosed by the recipient and may no longer be protected by federal or state law unless the records pertain to the Substance Use Disorder Records: 42 CFR part 2 prohibits unauthorized disclosure of these records.

With my signature the information specified above will be requested from the recipient designated above.

The Authorization is valid for 365 days from date of signature unless I indicate a different time or reason for expiration. See date ranges on other page. Once the information has been released, Holyoke Health Center Inc. cannot guarantee that the Recipient will not re-disclose the information to another party who may not be required to comply with state and/or federal laws governing the use and disclosure of protected health information (PHI) and, in such case, the PHI described above may be re-disclosed and would no longer be protected by such laws governing privacy of health information.

Release may take 10-15 business days for records to be processed and released. I will be notified when the records are ready for release. I am aware that there may be a fee for providing copies of my medical/dental record.

I have carefully read and understand the terms of this Authorization. I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby knowingly and voluntarily, authorize the disclosure of the above protected health information to the designated person/entity as specified above. I give my permission to share my protected health information, which may include protected or privileged information, in written and/or other stored format.

Patient/Guardian Signature: _____ Date: ____/_____/_____

If not signed by person served, specify relationship: · Parent · Legal Guardian/Designee

☐ **I authorize the following to pick up my records:**
Name: _____ Date: ____/_____/_____

☐ HHC Personnel or Witness**:** _____

Holyoke Health Center, Inc.

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

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

Medical/Dental History Form

Patient Medical History:

Physician Name: _____ Office Phone: _____ Date of Last Exam: _____

Please answer the following questions:	**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 five years? If so please explain: _____ _____ _____		
3. Are you taking any medication (s) including non-prescription medications? * please list medications on medication list page		
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. Are you wearing contact lenses?		
10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3weeks)?		
11. Are you allergic to or have you had any reactions to the following?		
▪ Local Anesthetics		
▪ Penicillin or any other Antibiotics		
▪ Sulfa Drugs		
▪ Barbiturates		
▪ Sedatives		
▪ Iodine		
▪ Any metals (e.g nickel, mercury ect.)		
▪ Latex Rubber ▪ Aspirin ▪ Ibuprofen		
▪ Other (* please list on next page)		

Allergies:

_____

_____

_____

_____

Current Medication List:

Medication & Dose	Frequency	Purpose

Please answer the following questions: **Women Only**	Yes	No
1. Are you pregnant or think you may be?		
2. Are you nursing?		
3. Are you taking oral contraceptives?		

Do you have or have you had any of the following?

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

Patient Dental History:

Name of Previous Dentist and location: _____ Date of Last Exam: _____

Please answer the following questions:	Yes	No
1. Do your gums bleed while brushing/flossing?		
2. Are your teeth sensitive to hot or cold liquids/foods?		
3. Do you feel pain on any of your teeth?		
4. Do you have any sores or lumps in or near your mouth?		
5. Have you had any head, neck or jaw injuries?		
6. Have you experienced any of the following problems?		
▪ Clicking		
▪ Pain (joint, ear, side of face)		
▪ Difficulty in opening or closing		
▪ Difficulty in chewing		
7. Do you have frequent headaches?		
8. Do you clench or grind your teeth?		
9. Do you bite your lips or cheeks?		
10. Have you ever had any difficult extractions in the past?		
11. Have you ever had prolonged bleeding following an extraction?		
12. Have you had any orthodontic treatment?		
13. Do you wear partials or dentures?		
14. 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 payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefit otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

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

Doctor's Comments:

_____

_____

_____

Providers Signature: _____ **Date:** _____