Patient Registration Form (Please Print)

Title: [ ]Mr [ ] Miss [ ] Ms [ ] Mrs [ ] Dr	Name First:	Middle:	Last:		Preferred Name/Nickname:
Birth Date:	Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ] Other				
Mailing Address:			Physical Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone: Home	Cell		Work		
May we contact you at home?[ ] yes [ ] no			May we contact you at work:[ ] yes [ ] no		
If the answer is no to the above, with whom may we leave a message? Phone: Home Cell Work					
May we say the "Northern Counties Health/Dental Center" is calling? [ ] Yes [ ] No					
Email:					
Preferred method of contact:[ ] Letter[ ] Home Phone [ ] Cell Phone [ ] Work Phone [ ] Email					
Gender: [ ] Male [ ] Female			Social Security #:		
Primary Language: [ ] English [ ] Spanish [ ] French [ ] Other _____ Translation Needed: [ ] Yes [ ] No					
Race: [ ] White [ ] Asian [ ] Black or African American [ ] American Indian or Alaska Native [ ] Native Hawaiian or Other Pacific Islander [ ] Other _____ [ ] Decline to provide					
Ethnicity: [ ] Hispanic [ ] Non-Hispanic [ ] Decline to provide					
If patient is a minor: Legal Custodian (parent/mother/father/guardian): DOB: Address (if different from patient): Physical Custodian (parent/mother/father/guardian): DOB: Address (if different from patient):					
As a Federally Qualified Health Center, we are REQUIRED by Federal Law to collect the following information for statistical purposes only. This is reported annually on a total patient basis. Individual patient information is not reported or disclosed. Thank you for your cooperation!					
Employment Status: [ ] Employed [ ] Unemployed [ ] Disabled [ ] Retired					
Homeless Status: [ ] Homeless [ ] not homeless					
Household Income: Total Gross Household Income: $ per [ ] week [ ] month [ ] year [ ] Decline to provide Size: **Number of people in household this supports**:					
Are you a Migrant Farm Worker? [ ] No [ ] Yes Migrant Work Status: [ ] Migrant Worker [ ] Seasonal Worker [ ] Decline to provide					
Veteran Status: [ ] Veteran [ ] Non-Veteran					
Preferred Pharmacy:			Location of Pharmacy:		
Emergency Contact:			Relation:		
Mailing Address:			Physical Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone: Home	Cell		Work		
Does contact know you are an NCHC patient? [ ] Yes [ ] No					

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Medical Insurance Info:

[ ] Self Pay/Uninsured [ ] Sliding Fee Scale Application completed

Primary Medical Insurance: [ ] Copy of card given

Policy Holder: [ ] Patient [ ] Spouse [ ] Parent [ ] Other_____
Name and Date of Birth:

Secondary Medical Insurance: [ ] Copy of card given

Policy Holder: [ ] Patient [ ] Spouse [ ] Parent [ ] Other_____
Name and Date of Birth:

Dental Insurance Info: Do you have a dentist: [ ] yes then who is it _____ [ ] no

[ ] Self Pay/Uninsured [ ] Sliding Fee Scale Application completed

Primary Dental Insurance: [ ] Copy of card given

Policy Holder: [ ] Patient [ ] Spouse [ ] Parent [ ] Other_____
Name and Date of Birth:

Secondary Dental Insurance: [ ] Copy of card given

Policy Holder: [ ] Patient [ ] Spouse [ ] Parent [ ] Other_____
Name and Date of Birth:

How did you hear about our services?

[ ] Other Patient [ ] Radio [ ] TV [ ] Yellow Pages
[ ] Website [ ] Physician [ ] None of the above

Acknowledgements:

Initial_____ I certify that the information I have given is complete and accurate to the best of my knowledge. I understand that failure to provide accurate information may result in termination of services at NCHC and reporting of the failure to the federal government.

Initial_____ I hereby give my consent for the staff of the Northern Counties Health Care, Inc. to render such diagnostic treatment, treatment services, and ongoing care as may be deemed necessary to me or my child up to age 18 or until such guardianship is discontinued.

Initial_____ I request NCHC to provide me and/or my family with medical/dental care and request that NCHC bill my insurance company directly. I authorize release of any medical or other information necessary to process my claims. I also authorize payment of medical benefits to NCHC

Initial_____ I understand that I am responsible for any deductibles, co-payments, non-covered service, or Sliding Fee Scale. I understand that my failing to do so may result in my being submitted to collections, reported to the credit bureau, and / or terminated from services at NCHC

Initial_____ I acknowledge that I have received from NCHC the 1) Patient's Bill of Rights/Contract of Care. 2) HIPAA Notice of Privacy Practices

Patient/Guarantor Signature: Date: / /

(rev 2, 1/04/2016)

Caledonia Home Health Care & Hospice
161 Sherman Drive
St. Johnsbury, VT 05819
P: 802-748-8116
F: 802-748-4628

Concord Health Center
201 East Main Street
P.O. Box 355
Concord, VT 05824
P: 802-695-2512
F: 802-695-1303

Danville Health Center
26 Cedar Lane
P.O. Box 185
Danville, VT 05828
P: 802-684-2275
F: 802-684-3839

Hardwick Area Health Center
4 Slapp Hill
P.O. Box 535
Hardwick, VT 05843
P: 802-472-3300
F: 802-472-8277

Island Pond Health & Dental Center
82 Maple Street
P.O. Box 425
Island Pond, VT 05846
P: 802-723-4300
F: 802-723-4544

Northern Counties Dental Center
151 N. Main Street
P.O. Box 537
Hardwick, VT 05843
P: 802-472-2260
F: 802-472-2263

St. Johnsbury Community Health Center
185 Sherman Drive
St. Johnsbury, VT 05819
P: 802-748-5041
F: 802-748-5094