



COMMUNITY HEALTH CENTER OF BURLINGTON
PATIENT REGISTRATION FORM

STAFF USE ONLY

MEDICAL DENTAL Riverside Safe Harbor Pearl Street Pine Street

PATIENT INFORMATION

LASTNAME		FIRSTNAME		MI
STREET ADDRESS		CITY	STATE	ZIP
SOCIAL SECURITY #	DATE OF BIRTH	HOME PHONE	DAY PHONE	
EMAIL ADDRESS		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> TRANSGENDER	GENDER FOR INSURANCE PURPOSES <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Civil Union		RACE <input type="checkbox"/> African-American <input type="checkbox"/> Native American <input type="checkbox"/> Asian-American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Multi-racial		Primary Language if Not English: _____ Do You Need Interpreter Services? <input type="checkbox"/> YES <input type="checkbox"/> NO Ethnicity/Ethnic Origin: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
Primary Care Physician		AGRICULTURAL WORKER <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal	Are You a U.S. Veteran? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HOW DID YOU HEAR ABOUT US? <input type="checkbox"/> Hospital Referral <input type="checkbox"/> Outreach Worker <input type="checkbox"/> Friend <input type="checkbox"/> Facebook <input type="checkbox"/> Doctor/Dentist Referral <input type="checkbox"/> Emergency Room Referral <input type="checkbox"/> Work <input type="checkbox"/> Other: _____ <input type="checkbox"/> Telephone Book <input type="checkbox"/> Newspaper <input type="checkbox"/> Website				FAMILY FINANCIAL INFORMATION Family/Household Size: _____ Household Income: \$ _____ As a Health Center that receives Federal Funding, we are required to collect this information. All answers are confidential.
HOUSING STATUS Are You Homeless? <input type="checkbox"/> YES <input type="checkbox"/> NO If homeless, are you: <input type="checkbox"/> Doubling Up (living w/others) <input type="checkbox"/> Shelter <input type="checkbox"/> Street <input type="checkbox"/> Transitional <input type="checkbox"/> Unknown				

RESPONSIBLE PARTY INFORMATION (Any patient under 18 must have a responsible party)

Patient (18 years or older) Custodial Parent Guardian (proof of legal status required for treatment) Foster Parent (proof of legal status required for treatment)

LASTNAME		FIRSTNAME		MI
STREET ADDRESS		CITY	STATE	ZIP
SOCIAL SECURITY #	DATE OF BIRTH	HOME PHONE	RELATIONSHIP TO PATIENT	

DENTAL INSURANCE INFORMATION

I currently have DENTAL insurance (see below)
 I currently DO NOT have DENTAL insurance
 I would like to apply for the SLIDING FEE SCALE

Dental Insurance Name: _____
Policy Number: _____
Group Number: _____
Billing Address for Insurance: _____

Policy Holder's Name: _____
Policy Holder's DOB: _____
Policy Holder's Employer: _____
Phone Number for Insurance: _____

MEDICAL INSURANCE INFORMATION

I currently have MEDICAL insurance (see below)
 I currently DO NOT have MEDICAL insurance
 I would like to apply for the SLIDING FEE SCALE

Medical Insurance Name: _____
Policy Number: _____
Group Number: _____
Billing Address for Insurance: _____

Policy Holder's Name: _____
Policy Holder's DOB: _____
Policy Holder's Employer: _____
Phone Number for Insurance: _____

EMERGENCY CONTACT

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
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I understand that to the best of my knowledge that the preceding answers are true and correct. _____
Signature of Patient or Personal Representative

COMMUNITY HEALTH CENTER OF BURLINGTON, INC.

**CONSENT TO TREATMENT AND CONSENT TO RELEASE OF
HEALTH INFORMATION FOR TREATMENT, PAYMENT
AND HEALTH CARE OPERATIONS**

I. Consent to Treatment

I hereby give my consent for treatment for myself, or the named patient (of whom I am the parent or legal guardian who has the right to consent to treatment for the named patient) to the Community Health Center of Burlington, Inc. (CHCB). Treatment may include health screening, diagnosis, medical treatment, dental care; social services; and/or mental health and drug and alcohol screening, assessment, diagnosis and treatment.

II. Consent to Release of Health Information, including Health/Treatment Records for Treatment, Payment and Health Care Operations

I consent to the use within CHCB and the disclosure to persons or organizations outside of CHCB of my (or of the named patient for whom I am the parent or legal guardian) medical, dental, drug and alcohol, mental health and other treatment and health records and information (such health records and information are referred to in this Consent as my "Health Information") by CHCB for the following purposes:

A. Use of Health Information By or For CHCB for Treatment and for Health Care Operations:

- Providing treatment by CHCB staff;
- Conducting health care operations of CHCB including, for example, financial or quality assurance audits and training.

B. Disclosure of Health Information to Persons Outside CHCB for Treatment Purposes and for Payment

- Providing Health Information to other health providers or agencies who are or will be involved in my care (except for treatment information concerning drug or alcohol abuse, for which a separate consent is required);
- Obtaining payment for health care bills, including sending such Health Information as is needed to secure payment for CHCB services to the insurance company, worker's compensation company or agency that pays for my health services, as identified in my CHCB Registration form or other updated insurance information on file with CHCB.

III. Other Matters

I understand that I have the right to revoke this Consent at any time, but revoking this Consent will not affect any actions which were taken by CHCB in reliance on this Consent before I revoked it. If not previously revoked, this consent will terminate on the following date, event, or condition: _____. If none is indicated, this consent will terminate three years after the last date of services to me.

I understand that I may request restrictions on use or disclosure of my Health Information for the purposes described in this Consent and that CHCB may or may not agree to the requested restrictions. I also understand that except for those restrictions on use or disclosure of Health Information to which it agrees, CHCB will not be able to provide services to me (or the named patient) without this signed Consent.

I understand and acknowledge that I am financially responsible for any unpaid balances incurred as a result of my care at CHCB.

I HAVE READ ALL OF THE INFORMATION ABOVE AND I UNDERSTAND AND CONSENT TO ITS CONTENT.

Name of Patient (please print)

Signature of Patient or Personal Representative

Date of Birth _____

Date: _____

Name of Personal Representative (please print)



617 Riverside Avenue
Burlington, VT 05401
(802) 864-6309

Patient Name: _____ DOB: _____

PERMISSION TO RELEASE PATIENT INFORMATION

If you have a spouse, friend or relative that may call on your behalf to obtain appointment dates and times, test results, etc., we **will not** give that information out unless his/her name(s) is provided for our records. I hereby give permission to the Community Health Center of Burlington to allow receipt of the following to those listed below should he/she call or come in to inquire. Please check what you will allow to be released.

- Medical Test Results
- Medications
- Appointment Confirmation
- Other _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

- I do not** consent to information about me to be released to others, except as I have consented, or may in the future consent in other authorizations or consents provided to me by the Community Health Center of Burlington, or as required by law.

Patient at the Community Health Center of Burlington consent to disclosure of information for purposes of treatment, payment and health care operations. Patient may consent to receipt or disclosures of health care information for other purposes as well.

Patients requesting information in regards to drug and alcohol counseling/treatment need to complete a separate authorization. No drug and alcohol information will be given out with this permission.

USE OF E-MAIL

I understand that CHCB and I may exchange information via e-mail per my request.

- I do wish to have CHCB contact me via e-mail. This may include appointment confirmations.
- I do not wish to have CHCB contact me via e-mail.

ABOUT OUR NOTICE OF PRIVACY PRACTICES

We are committed to protecting your personal health information in compliance with the law. CHCB's Notice of Privacy Practice states:

- Our obligations under the law with respect to your personal health information
- How we may use and disclose the health information that we keep about you
- Your rights relating to your personal health information
- Our rights to change our Notice of Privacy Practices
- How to file a complaint if you believe your privacy rights have been violated
- The conditions that apply to uses and disclosures not described in this Notice
- The person to contact for further information about our Privacy Practices

We are required by law to give you a copy of this notice and obtain your written acknowledgement that you have received a copy of the Notice.

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices, I have completed the Permission to Release Patient Information and have completed and understand the use of e-mail.

Patient's Name: _____

Signature of Patient or Patient's Representative: _____

Description of Legal Authority to Act on Behalf of the Patient: _____

Date: _____



DENTAL - Medical History Form

Patient Name: _____ Date of Birth: _____ 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

Has there been a major change to your health within the past year?.....

Are you under the care of a physician or are you receiving ongoing medical care?

Name and address of your physician: _____

Physician's Phone Number: _____

Date of your last medical visit: _____

Are you pregnant?

If Yes, due date: _____

Do you have any artificial joints, valves, implants, or prosthesis?

Have you had surgery, x-ray treatment, or chemotherapy for a tumor, growth, or other condition?

If yes, please explain: _____

Medications:

Please check the answer that is right for you, "Yes", "No", "DK" (Don't Know):

Yes	No	DK	Yes	No	DK		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerine..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Hormone Therapy..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antihistamines	<input type="checkbox"/>	<input type="checkbox"/>	Anticoagulants (Blood Thinners)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Digitalis	<input type="checkbox"/>	<input type="checkbox"/>	Tranquilizers	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control.....	<input type="checkbox"/>	<input type="checkbox"/>	Insulin (Orinase)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa	<input type="checkbox"/>	<input type="checkbox"/>	Synthroid	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone (steroids)	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>		

Please list the drug name, dosage, and frequency:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Dental

Yes No DK

Are you having any discomfort at this time?.....

If yes, please explain: _____

Have you ever had serious trouble associated 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: _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Allergies:

Please check the answer that is right for you, "Yes", "No", "DK" (Don't Know):

Yes	No	DK	Yes	No	DK		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics.....	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives, Barbiturates, or Sleeping Pills.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex.....	<input type="checkbox"/>	<input type="checkbox"/>	Iodine.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>		

Other:

Please check the answer that is right for you, "Yes", "No", "DK" (Don't Know):

Yes No DK

Do you use tobacco?.....

What? _____ How much? _____

Do you use alcohol?

What? _____ How much? _____

Do you have any CURRENT/PAST history of substance use?

If yes, please explain: _____

Patient Name: _____ Date of Birth: _____ Date: _____

Medical Information:

Please check the answer that is right for you, "Yes", "No", "DK" (Don't Know).

<p>Heart and Circulatory Problems</p> <p>Yes No DK</p> <p>Heart Attack <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>High Blood Pressure..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chest Pain (Angina) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart Murmurs..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Artificial Valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other Heart Problems..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Stomach Problems</p> <p>Yes No DK</p> <p>Stomach Pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heartburn..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>History of Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Colitis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Neurologic Problems</p> <p>Yes No DK</p> <p>Epilepsy/Seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chronic Headaches <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>History of Head Injury..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Numbness of Arms, Legs, Hands or Feet <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>History of Stroke..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Fainting Spells..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Yes No DK</p> <p>Diabetes - Type I <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes - Type II <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid Problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other Gland Problems.... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Mental Health Problems</p> <p>Yes No DK</p> <p>Depression <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Anxiety..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>History of Psychiatric Medications <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Blood Problems</p> <p>Yes No DK</p> <p>Bleeding Problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hemophilia..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Breathing/Lung Problems</p> <p>Yes No DK</p> <p>Hay Fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Shortness of Breath..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Persistent Cough..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Positive Test/Treatment for Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Seasonal Allergies..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Emphysema..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Coughing up Blood <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Muscle and Bone Problems</p> <p>Yes No DK</p> <p>Joint/Back Pain..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>History of Broken Bones <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Joint Swelling..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Other</p> <p>Yes No DK</p> <p>Domestic Abuse..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Immune System Disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Venereal Disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>AIDS/HIV <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Kidney or Bladder Problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Frequent Urinary Tract Infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Pregnant..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you have any other disease, condition or problem not listed? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If Yes, please explain _____</p>
<p>Skin Problems</p> <p>Yes No DK</p> <p>Rashes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Mole Changes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Liver</p> <p>Yes No DK</p> <p>Hepatitis A, B, or C <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Alcoholic Liver Disease..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other Liver Disease..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Jaundice <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	

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 Community Health Center/Dental Center of Burlington.

We have reserved your appointment time for you alone and it is most important that you keep your appointment. If you must cancel your appointment, we require 24-hour notice by phone or in person. If you fail to keep your appointment and do not notify us, you will not be able to reschedule your appointment and you will have to call for a Same Day appointment. Failure to keep a second appointment without 24-hour notice may be grounds for termination of your patient status at the Dental Center of Community Health Center of Burlington. Your cooperation with our appointment policy is appreciated by our entire staff.

Signature of patient or guardian

Date

Signature of Doctor

Date