Thank you for choosing Mid-State Health Center to care for your health needs.

Our goal at Mid-State is provide top-notch care to each of our patients, Mid-State has a team of highly skilled providers and a variety of services available to help you achieve your health goals. We encourage you to visit our website at www.midstatehealth.org to "Meet Our Providers" and view our full list of services. Our New Patient Team can assist you in finding a provider that best meets your health goals.

Attached you will find our **Health History Form** which includes important questions regarding your health, as well as a **Release of Information** which will allow us to receive your previous health records. **Please complete and sign each of these forms and return to Mid-State Health Center within 30 days of receiving them.**

Completed forms can be returned to Mid-State via:

- Mail: Mid-State Health Center
  Attn: New Patient Team
  101 Boulder Point Drive, STE 1
  Plymouth, NH 03264
- Email: healthnavigators@midstatehealth.org
- Fax: 603-536-4001
- Or dropped at any of our locations.

Once we receive your completed paperwork and your previous medical records, a member of our team will contact you to schedule an appointment. **Please note that receiving your medical records from your previous provider may take up to 45 days.**

If you have an **immediate health concern before your first visit**, please call our office.

If you have any questions, or need assistance in completing paperwork, please contact our New Patient Team by calling 603-536-4000 Ext. 1550.

Wishing you good health,

The Mid-State Health Center Team

Mid-State Health Center
Patient Registration

Services Requested

Services Requested (Check all that apply): ☐ Medical ☐ Behavioral Health ☐ Dental ☐ Recovery ☐ Physical Therapy

Patient Information

Prefix: ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐ Other: _____

Last Name: _____ First Name: _____ M.I.: _____ Suffix: _____

Preferred/Nick Name: _____ Preferred Pronoun: ☐He ☐She ☐Other _____

Legal Gender: ☐ Female ☐ Male Social Security # _____ - _____ - _____ Date of Birth / _____ / _____

Phone: Home (_____) _____ Cell (_____) _____ Work (_____) _____

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

☐ Street address is the same as mailing address

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

Email: _____

Preferred Language: ☐ English ☐ French ☐ Spanish ☐ Other: _____

Do you wish to have translation/interpreter services for your visits? (Offered at no cost): ☐ Yes

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow/Widower ☐ Other: _____

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other: _____

Ethnicity: ☐ Hispanic/Latino/Latina ☐ Not Hispanic/Latino/Latina

Have you ever served in the military? ☐ Yes ☐ No If yes, what is your current status: _____

Emergency Contact (person we contact only in an emergency):

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip _____

Phone: Home (_____) _____ Cell (_____) _____ Work (_____) _____

Statistical Information As a Federally Qualified Health Center, Mid-State is *required* by Federal Law to request the following information for *statistical purposes only*. *Individual patient information is NOT reported or disclosed*. Thank you for your participation.

Are you: Homeless? ☐ Yes ☐ No A Migrant/Seasonal Worker? ☐ Yes ☐ No

Income: ☐ Below $24,999 ☐ $25,000-$49,999 ☐ $50,000-$74,999 ☐ $75,000-$99,999 ☐ $100,000 or more

Household Size: Number of people in household including yourself: _____

Patient Health Information

Primary Support: ☐ Self ☐ Spouse ☐ Parents ☐ Other:_____

Occupation:_____ Retired: ☐ Yes ☐ No ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐ Other _____

Do you think of yourself as**:** ☐ Straight or Heterosexual ☐ Lesbian, Gay, or Homosexual ☐ Bisexual
☐ Something else ☐ Not sure

Do you identify as transgender or transsexual? ☐ Yes ☐ No ☐ Not sure

Patient's number of children: Daughter(s):_____ Son(s): _____

Do you have a living will? ☐ Yes ☐ No Are you an organ donor? ☐ Yes ☐ No

ONLY for Patients Under the age of 18 years old, please complete the following:

Parent's Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Re-married ☐ Widow/Widower ☐ Other _____

I live with(their name):_____ Relationship to you: _____

Current Medications & Supplements

Medication/Supplement Name	Dosage	Frequency	Prescribing Provider

* If you have more medications/supplements than space allows, please attach a full and complete list.

Allergies

Please list any known allergies. Include any medication allergies, seasonal allergies, bees, shellfish, etc.

List what you are allergic to: Reaction:

_____ _____

_____ _____

_____ _____

Hospitalizations (Non-Surgical Only)

Date	Reason (Diagnosis)	Hospital	Attending Physician

Patient Name:_____ Date of Birth: _____

Surgical History

Date	Procedure / Surgery	Hospital	Physician

Current and Past Medical Conditions – Check all that apply

Alcohol/Drug Problems	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Hemorrhoids	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Hepatitis/Yellow Jaundice	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Bleeding Problems	☐ Yes	☐ No	HIV	☐ Yes	☐ No
Cancer of _____	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No	Kidney Stones	☐ Yes	☐ No
Chronic Bronchitis	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Reaction to Anesthesia	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Emphysema/COPD	☐ Yes	☐ No	Skin Disease/Dermatitis	☐ Yes	☐ No
Gall Bladder Disease/Stones	☐ Yes	☐ No	Stomach Ulcers	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Gout	☐ Yes	☐ No	Tuberculosis/Positive PPD	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Vision Problems	☐ Yes	☐ No
Head or Neck Radiation	☐ Yes	☐ No	Other: _____	☐ Yes	☐ No
Hearing Difficulty	☐ Yes	☐ No	Other: _____	☐ Yes	☐ No

Family History

List any diseases that your relatives have/had:

Father: _____

Mother: _____

Brother(s):_____ Sister(s):_____

Son(s):_____ Daughter(s):_____

Immunizations

☐ Immunizations Attached			☐ Tetanus/Pertussis (DTap)	Y	N
☐ Flu (Influenza)	Y	N	☐ Chicken Pox (Vericella)	Y	N
☐ Polio (OPV)	Y	N	☐ Measles,Mumps,Rubella (MMR)	Y	N
☐ Hepatitis B	Y	N	☐ Tuberculosis (TB) Test	Y	N
☐ COVID-19 (Two Doses)	Y	N	☐ Other:_____		

Health Screenings (please provide the date of your most recent screening)

☐ Physical Exam (_____/_____)

☐ Cholesterol Check (_____/_____)

☐ HIV Screening (_____/_____)

☐ Hep C Screening (_____/_____)

☐ Mammogram (_____/_____)

☐ Pap Smear (_____/_____)

Colon Cancer Screening:

☐ Colonoscopy (_____/_____)

☐ Fecal immunochemical testing (_____/_____)

☐ Stool Test for Blood (_____/_____)

☐ PSA Test/Prostate Cancer Screening (_____/_____)

☐ Diabetes Screening (☐ fasting blood sugar or ☐ HgbA1c) (_____/_____)

Payment Information

Party Responsible for Payment: ☐ Self ☐ Parent ☐ Spouse ☐ Other: _____

Complete this section about the person responsible for payment ONLY if someone other than the patient

Full Name (of person responsible for payment): _____

Relationship to Patient: _____ Social Security # ___ - ___ - ____ Date of Birth ___/___/____

Phone: Home (___) _____ Cell (___) _____ Work (___) _____

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

☐ Street address is the same as mailing address

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

Insurance Coverage Information

Patient Insurance Coverage: ☐ Insured ☐ Insured, but with high deductibles ☐ Uninsured

We can help. Mid-State offers a variety of payment options for those patients who have insurance plans with high deductibles or no insurance. Visit our website at midstatehealth.org for more information.

☐ **Please check here if the patient (or person responsible for payment) would like to meet with a Patient Account Representative** to discuss payment options or to determine if the patient is eligible for Mid-State's sliding fee scale program.

Primary Insurance: _____ Phone: (___) _____

Policy ID#: _____ Group#: _____ Co-pay for Office visit: $ _____

Policy Holder's Name: _____

If the policy holder is not the patient, please complete the following information about the policy holder:

Relationship to Patient: _____ Social Security # ___ - ___ - ____ Date of Birth ___/___/____

Secondary Insurance: _____ Phone: (___) _____

Policy ID#: _____ Group#: _____ Co-pay for Office visit: $ _____

Policy Holder's Name: _____

If the policy holder is not the patient, please complete the following information about the policy holder:

Relationship to Patient: _____ Social Security # ___ - ___ - ____ Date of Birth ___/___/____

How did you hear about Mid-State: ☐ Friend/Relative ☐ Online Search ☐ Newspaper ☐ Radio

☐ Facebook ☐ Mid-State's Website ☐ Emergency Room ☐ Other: _____

MID-STATE HEALTH CENTER

HIPAA Compliant Authorization for Disclosure of Protected Health Information
New Patient - Medical

Name:_____ **Date of Birth:**_____

I hereby authorize the following entity to disclose/release my protected health information (PHI) orally or in writing for the following purpose of **Continuity of Care.**

Organization Name:_____

Address:_____

Phone:_____ Fax: _____

I understand this information may include treatment for drug/alcohol abuse, mental illness, HIV status, or genetic testing records. **I specifically authorize the release of this information** (if applicable):
☐ Yes ☐ No Initials:_____

Name of person(s) or entity to receive information:
Mid-State Health Center
101 Boulder Point Drive, Suite 1
Plymouth, NH 03264

INFORMATION TO BE DISCLOSED:
Information Needed:

☐ Problem List	☐ Last office visit notes	☐ Last two years of labs
☐ Immunization	☐ Last two physicals	☐ Last two pap
☐ Medication List	☐ Dexa	☐ Last 2 mammo
☐ EKG, Echo	☐ Colonoscopy/Pathology Reports	

I understand that:

- I may refuse to sign this authorization and my healthcare and payment of my healthcare will not be effected based upon refusal to sign the authorization.
- I may revoke this authorization at any time by delivering to the health care provider/institution, authorized above, in a written note. I understand that the revocation will not apply to records that have been disclosed prior to receipt of the written revocation.
- If I authorize disclosure of my protected health information, and the recipient is not a covered entity, the recipient may further disclose this information and federal law will no longer protect it.
- I have the right to inspect a copy of the information that I am consenting to release within the established policies of the provider or institution that I authorize to release my records.

This authorization will expire one year from the date this document is signed unless I otherwise specify an alternative date or event described here: _____

Signature of Patient/Personal Representative	Phone Number	Date
Printed Name of Personal Representative	Legal Authority of Personal Representative	

MID-STATE HEALTH CENTER
101 Boulder Point Drive, Suite 1
Plymouth, NH 03264
P: 603-536-4000 | F: 603-536-4001
midstatehealth.org

Designation of Personal Representative - *Optional*

Patient Name: _____ **DOB:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone Number:** _____

I hereby designate the following Personal Representative to **assist me in exercising my health information rights,** related to care received at Mid-State Health Center, under the New Hampshire Patient's Bill of Rights (NH RSA 151:19-21) and the Federal Privacy Rule (45 CFR 164.502(g).

You may nominate a Personal Representative to assist in obtaining and receiving services at MSHC. This Personal Representative does not have equal rights and responsibilities as a Durable Power of Attorney. The Representative can only assist in exercising your **health information rights.**

My designated Personal Representative is:

Name: _____ **Phone:** _____ **Relation to patient:** _____

Address: _____ **City/ State:** _____ **Zip Code:** _____

I request that my Personal Representative be allowed to assist me in exercising the following rights related to my **protected health information (PHI)**: (check all that apply)

_____ The right to execute, on my behalf, any medical consents, or other documents that may be required in order to exercise my health information rights; (including sliding fee application)

_____ The right to request and obtain a copy of my **medical records** and other PHI

_____ The right to request an amendment of any of my protected health information and/or request an accounting of disclosures of my protected health information

_____ The right to **communicate verbally** regarding my appointments; (cancel, schedule or reschedule)

_____ The right to have verbal discuss my health concerns with my provider and care team

_____ Other (please specify:)_____

_____

Restriction(s): _____

_____

☐ No expiration Date

☐ Expires on (MM/DD/YYYY): _____

I understand if I wish to revoke personal representative designation, I must deliver notice of written revocation to: Mid-State Health Center – Health Information Management. I understand that it is my responsibility to notify my designee that I have revoked their personal representative designation. Submitting additional Personal Representative Forms will **NOT** revoke existing forms.

_____ _____

Patient's Name **(Print)** Date:

_____ _____

Patient **(Signature)** / Legal Guardian (Signature) Printed Legal Guardian's Name (If Applicable)