MID-STATE HEALTH CENTER

Where your care comes together.

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

To get started, please complete and return the attached forms to our office:

☐ **New Patient Registration Form** (includes important information about you)

☐ **Dental Health History Form** (includes important information about your oral health history)

☐ **Protected Health Information Release Authorization** (allows up to obtain your previous health records)

Optional Forms:

☐ **Designation of a Personal Representative**

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:

- Email: dental.info@midstatehealth.org
- Fax: 603-536-4001
- Mail: Mid-State Health Center, [Attn: Tim R. for Bristol, Attn: Kim P. for Littleton], 101 Boulder Point Drive, STE 1, Plymouth, NH 03264
- Or dropped at any of our locations.

Please note that receiving your medical records from your previous provider may take up to 30 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 Dental Team by calling 603-744-6200.

Wishing you good health,

The Mid-State Health Center Team

MID-STATE HEALTH CENTER

Mid-State Health Center
New Patient Registration

Services Requested: ☐ **Primary Care** ☐ **Behavioral Health** ☐ **Dental (BRISTOL OR LITTLETON)**
☐ **Physical Therapy (PLYMOUTH)** ☐ **RISE Recovery**

PATIENT INFORMATION

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

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

Preferred /Nickname: _____ **Maiden Name:** _____ **Gender at Birth:** ☐ Male ☐ Female

Social Security Number: _____-_____-_____ **Date of Birth**: _____/_____/_____

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

Preferred Pronoun: ☐ He/Him ☐ She/Her ☐ They/Them

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

Ethnicity: ☐ Hispanic / Latino / Latina ☐ Non-Hispanic / Latino / Latina

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

Mailing Address: _____ City: _____ State: _____ Zip: _____
☐ Street address is the same as mailing address

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

Phone: Home: _____ Cell: _____ Work: _____

Email: _____

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:** _____

Street 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 your household including yourself: _____

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 patient): _____

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 ☐ Social Media ☐ Mid-State's Website

☐ Emergency Room ☐ Other: _____

MID-STATE HEALTH CENTER

Mid-State Health Center
DENTAL New Patient Health History

Name: _____ Date of Birth: _____

SURGICAL HISTORY (please complete to the best of your ability)

Date	Procedure/Surgery	Hospital	Physician

CURENT AND PAST MEDICAL CONDITIONS – PLEASE CHECK ALL THAT

Alcohol/Drug Problems	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Hepatitis/Yellow Jaundice	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Bleeding Problems	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Bowel Disease	☐ 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	Migraines	☐ Yes	☐ No
Chronic Pain	☐ Yes	☐ No	Prostate Enlargement	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Reaction to Anesthesia	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Skin Disease	☐ Yes	☐ No
Eating Disorders	☐ Yes	☐ No	Stomach Ulcers	☐ Yes	☐ No
GERD/Acid Reflux	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Gout	☐ Yes	☐ No	Tuberculosis / Positive PPD	☐ Yes	☐ No
Hearing Difficulty	☐ Yes	☐ No			

PATIENT HEALTH INFORMATION

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

Occupation: _____ **Retired?** ☐ Yes ☐ No

Do you think of yourself as: ☐ Straight or Heterosexual ☐ Lesbian, Gay, or Homosexual ☐ Bisexual ☐ Something else ☐ Other

Do you identify as transgender or transexual? ☐ 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

CURRENT MEDICATIONS AND SUPPLEMENTS

Medication / Supplement Name	Dosage	Frequency	Prescribing Provider

If you have any 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, food allergies, bees, etc.

_____

_____

_____

HOSPITALIZATIONS (NON-SURGICAL ONLY)

Date	Reason (Diagnosis)	Hospital	Physician

THIS SECTION FOR ONLY PATIENTS UNDER THE AGE OF 18

Parent's Marital Status:

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

I live with: Name:_____ Relationship to You: _____

ORAL HEALTH INFORMATION

Please list any dental concerns you have:

Date of last dental visit?_____ Date of last dental cleaning?_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY

☐	Dental Pain	☐	Diabetes
☐	Bleeding Gums	☐	Eating Disorder
☐	Tooth Sensitivity	☐	Acid Reflux or GERD
☐	Unpleasant Taste or Mouth Odor	☐	Recreational Drug Use
☐	Head, Neck, Or Shoulder Pain	☐	Alcohol Use
☐	Numbness, Tingling, Burning Sensation in The Head or Neck	☐	Dry Mouth
☐	Jaw Pain	☐	Grinding Or Clenching Teeth
☐	Oral Cancer	☐	Chemotherapy/Radiation

Please answer the following questions to the best of your ability.	**Yes**	**No**	**Explain**
Have you used xylitol products more than 4 times/day for the last 6 months?	☐	☐	
Have you used a prescription mouth rinse (Chlorhexidine/Peridex) in the last 6 months?	☐	☐	
Have you used a calcium phosphate toothpaste (MI Paste) in the last 6 months?	☐	☐	
Do you wear any appliances or prostheses like night guards, retainers, or dentures?	☐	☐	
Do you have fluoride in your drinking water?	☐	☐	
Do you take any blood thinners? If yes, which ones? If you take Warfarin, do you know your last INR?	☐	☐	
Have you ever taken a premedication for dental appointments?	☐	☐	
Have you ever had periodontal surgery?	☐	☐	
Do you use fluoride toothpaste, mouth rinse, or prescription product?	☐	☐	
Do you have sugar containing snacks more than 4 times/day?	☐	☐	
Are you pregnant or breastfeeding?	☐	☐	
Have you had a major change in health in the past year (heart attack, stroke etc.)?	☐	☐	
Have you ever smoked cigarettes, cigars, or pipes If yes: packs/day, how many years? Have you quit?	☐	☐	
Have you ever used smokeless tobacco? If yes: how often, how many years? Have you quit?	☐	☐	
Have you ever used e-cigarettes or vaping products? If yes: how often, how many years? Have you quit?	☐	☐	

Please be advised that the weight capacity for the dental chairs is 300lbs. If your weight exceeds that limit, please inform a member of the staff so that alternative arrangements can be discussed

MID-STATE HEALTH CENTER

Mid-State Health Center:
Authorization to Release/ Disclose Protected Health Information

Patient Name: _____ **DOB:** _____

Instructions: Complete all applicable sections to have information disclosed **FROM** or **TO** Mid-State Health Center (MSHC). Refusal to complete this form will not affect the quality of or access to care, condition of treatment, payment, enrollment or eligibility for benefits.

Patient Notice – This Section Applies to All Requests

Note: This is a required section and must be completed in its entirety.

_____ I hereby authorize to disclose/ release my protected health information (PHI) orally or in writing **FROM**:

☐ Mid-State Health Center
101 Boulder Point Dr Suite 1
Plymouth, NH 03264
(P)603-536-4000 (F)603-536-4001

☐ _____
Organization Name:
_____
Address:
_____ _____
Phone # Fax #

(Check all that apply) ☐ Medical ☐ Behavioral Health ☐ Dental ☐ Physical Therapy
☐ IOP/Substance Use Disorder ☐ **All**

A. I request that the information be released for the following purpose: (**Initial** all that apply)

____ Transfer of Care	____ Attorney/ Legal	____ Billing or Claims	____ Review Request
____ Continuing Care	____ School	____ Insurance	____ Other: _____
____ Personal Use	____ Military	____ Financial Aid	
____ Disability		____ Self-Pay	

B. I request that the information be released **TO**:

☐ Mid-State Health Center, 101 Boulder Point Dr Suite 1, Plymouth NH 03264 (P) 603-536-4000 (F) 603-536-4001

☐ Name/ Facility Name: _____ Attn: _____
Address: _____City/ State: _____ Zip Code: _____
Phone: _____ Email: _____ Fax: _____

☐ Name/ Facility Name: _____ Attn: _____
Address: _____City/ State: _____ Zip Code: _____
Phone: _____ Email: _____ Fax: _____

C. All **record requests** will be delivered in an electronic format (CD or via electronic file portal), unless otherwise specified. Please initial requested delivery method:
____ Electronic File (CD) ____ Other: _____ ____ In Office Pick-Up (valid photo ID required)*
*To retrieve this information in person, a valid photo ID will be required for patient privacy and confidentiality purposes.

*I understand that a processing **fee may apply** for the requested information.

_____ I understand that my medical record may be incomplete and that additional documentation may be added when received

Records requested are in an electronic format (e.g. CD) unless paper specified above. Electronic signatures are not accepted.

☐ **MEDICAL Records – Initial ONLY Items That Apply**

A. Information to be released:

____ **Complete Medical Record**	____ Implant Records	____ X-Ray(s)	____ Billing Records
____ Office Visit Notes	____ Laboratory	____ Ultrasound/Sonogram	____ Demographics
____ Consultation Reports	____ Medication Lists	____Images ONLY	____ Family Studies
____ History & Physical	____ Pathology Report	____ Reports ONLY	
____ Immunizations	____ Psychiatry	____ Explanted Materials, Devices, Hardware	
____ Other: _____			

B. Time period or date of information to be released: (MM/YY) From: _____ To: _____
C. Specific Treating Provider Name(s): _____ OR ____ All Medical Providers
D. Specific Clinic/ Service(s): _____ OR ____ All Medical Services

MID-STATE HEALTH CENTER

Mid-State Health Center:
Authorization to Release/ Disclose Protected Health Information

☐ **DENTAL Records- Initial ONLY Items That Apply**

A. Information to be released:
____ All Dental Records ____ Dental Images (XRays) ____ Dental Office Notes
B. Time period or date of information to be released: (MM/YY) From: _____ To: _____
C. Specific Treating Provider Name(s): _____ OR _____ All Providers

☐ **BEHAVIORAL HEALTH Records – Initial Only Items that Apply**

A. Information to be released:
____ All Behavioral Health Records ____ Specific Provider: _____
B. Date(s) of information to be released (MM/YY): From _____ To: _____
____ **I understand that psychotherapy notes will not be included unless authorized by provider under 45 CFR 164.508(a)(2).**

☐ **PHYSICAL THERAPY Records- Initial ONLY Items That Apply**

A. Information to be released:
____ All Physical Therapy Records ____ Physical Therapy Office Notes ____ Initial evaluation/Progress Notes
B. Time period or date of information to be released: (MM/YY) From: _____ To: _____
C. Specific Treating Provider Name(s): _____ OR _____ All Providers

IOP/SUBSTANCE USE DISORDER – Initial Only Items That Apply

**** Must complete Authorization to Disclose Substance Use 42 Part 2 Form ****

Patient Acknowledgement – This Section Applies to All Requests

This authorization form does not authorize the release of Substance Use Therapy Records. A separate Authorization to Disclose Substance Use 42 Part 2 Form must be completed.

- I understand that the information in my health record may include information relating or referencing: Genetic counseling; Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) treatment; history of drug or alcohol abuse; mental, behavioral health, or psychiatric care; and/or other sensitive information.
- I understand that I may revoke this authorization in writing at any time, except to the extent that MSHC has relied on this authorization. The written revocation should be addressed to the Health Information Management Department. Unless otherwise revoked, I understand that the date upon which this authorization **expires is 180 days** unless otherwise specified _____.
- I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA).

_____	_____	_____
Patient's Printed Name:	**Patient's Signature:**	Date:
_____	_____	_____
*Legal Representative's Printed Name:	Legal Representative's Signature	Date:

***Note: Proof of legal authority may be required for legal representatives**

Return Form to: **Mid-State Health Center**
Health Information Management – Release of Information
101 Boulder Point Drive, Suite 1
Plymouth, NH 03264
Phone: 603.536.4000 **Fax**: 603.536.4001
Email: medicalrecords@midstatehealth.org

MID-STATE HEALTH CENTER

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)