MID-STATE HEALTH CENTER

*Where your care comes together.*

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

Our goal at Mid-State is to 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. Our Health Navigator Team will assist you in finding a provider that best meets your health goals.

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

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

☐ **New Patient Health History Form** (includes important information about your health)

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

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Once we receive your completed paperwork our team will contact you to schedule an appointment. **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 Health Navigator Team by calling 603-536-4000 Ext. 1550.

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
# New Patient Health History

Patient 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 | | | |

## FAMILY HISTORY

**List disease that your relatives have / had:**

Father:_____

Mother: _____

Sibling(s): _____

Son(s):_____Daughter(s): _____

## IMMUNIZATIONS

| | | | | | |
|---|---|---|---|---|---|
| Immunizations Attached | ☐ | | Tetanus/Pertussis (DTap) | ☐ Yes | ☐ No |
| Shingles | ☐ Yes | ☐ No | Chicken Pox (Varicella) | ☐ Yes | ☐ No |
| Pneumonia | ☐ Yes | ☐ No | Measles, Mumps, Rubella (MMR) | ☐ Yes | ☐ No |
| Polio (OPV) | ☐ Yes | ☐ No | ☐ Other: _____ | | |
| Hepatitis B | ☐ Yes | ☐ No | | | |
| COVID-19 | ☐ Yes | ☐ No | | | |

## HEALTH SCREENINGS (please complete to the best of your ability)

☐ Physical Exam _____
☐ Cholesterol Check _____
☐ HIV Screening _____
☐ Hep C Screening _____
☐ Mammogram _____
☐ Pap Smear _____
☐ Colonoscopy _____
☐ PSA Test / Prostate Cancer Screening _____
☐ Diabetes Screening _____
(☐ fasting blood sugar or ☐ HgbA1c)

## 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: _____

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.**

Facility 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 Smears |
| ☐ Medication List | ☐ Bone Density | ☐ Last 2 Mammograms |
| ☐ 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

# 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)