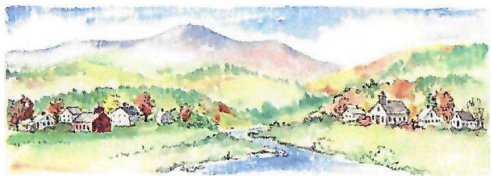
Mascoma Community Healthcare Medical Center



New/Renewal Registration Welcome to Mascoma Community Health Center! We realize that the paperwork in our New Patient Packet takes some time and thought to fill in, but we want to make sure that our providers have the information they need to take care of you, and that your dental record is complete and up to date.

Name: _____ Date of Birth: _____ Social Security Number _____

Mailing Address: _____ _____ City, State, Zip _____ Email: _____

Physical Address Eame as Mailing? Yes Add Phvsical Address if No: _____ _____

Preferred Phone _____ Home Cell Work Secondary _____ Home Cell Work

Marital Status: Married Divorced Partner Single Unknown Widowed Legally Separated

Gender: ☐ Female ☐ Male ☐ Other Employer: Address: _____

Employment Status: Full-time Yes No Part Time? Yes No Are you a seasonal worker? Yes No

MIiitary-Active Yes No Military- Reserves Yes No Student - Full-time Student - Part-time

Are you a Veteran? Yes No Branch of MIiitary Service: _____ Years of Service: _____

Emergency Contact

Is this person your legal guardian? Yes No Can we share your medical information with this person Yes No

Relationship to Patient: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City/State/Zip

If Minor, Mothers Name/Phone Father's Name /Phone

Insurance Information

Policy Holder: _____ Policy Holder Date of Birth: _____ Relationship to Patient: _____

Primary Insurance carrier: _____

Policy Number: _____ Group Number: _____

Insurance Type: Commercial Medicare Medicare Advantage Medicaid Tricare Other _____

Do you have a secondary insurance? Yes No If yes, what?

Responsible Party (Who is Responsible for Paying the Bill)

Self Other person (fillin below)

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Phone: _____ Social Security Number: _____ Relationship to Patient: _____

Pharmacy Information

Preferred Pharmacy: _____ Location: _____

Mail Order Pharmacy (if applicable): _____

Additional Information

Primary Language Spoked: English Spanish Other _____ Will you need interpreter? Yes No

Race / Ethnicity: Asian Black/African American Native Hawaiian Other Pacific Islander White

American Indian/Alaskan Native Hispanic/Latino Non-Hispanic/Latino Other/Refused to Report

Are you homeless? No Yes If yes Homeless Shelter Transitional Street Other

How many people live in your household (including yourself)? _____

Yearly Household Income: Less than $22,340 $22,341to $30,260 $30,261to $38,180

$38,181to $46,100 $46,101to $54,020 $54,021to $61,941or more Refuse to Report

I hereby give Mascola Community Healthcare, Inc, permission to obtain a history of my prescribed drugs during the course of my medical care. I attest that the information provided on this form is true and accurate.

_____ _____

Patient Signature **Date** For Office Use Only – Date Received: _____

As desired by Patient -

DESIGNATION OF PERSONAL REPRESENTATIVE

Name _____ DOB _____ Phone _____ Patient ID _____

I hereby designate the following Personal Representative to assist me in exercising my health information rights under the New Hampshire Patient's Bill of Rights (NH RSA 151:19-21) and the Federal Privacy Rule (45 CFR 64.502(g)), as indicated below.

My designated Personal Representative is:

Name: _____ Phone#: _____

Address: _____

My Personal Representative has the authority to execute on my behalf any releases or other documents that may be required in order to exercise my health information rights. I request that my Personal Representative be allowed to assist me in exercising the following rights related to my protected health information **(please check all applicable items):**

___ ___ Restrictions_____

_____

___ ___ The right to access and obtain a copy of my medical records and other protected health information;

___ ___ The right to authorize use or disclosure of my protected health information;

___ ___ The right to request an amendment of my protected health information;

___ ___ The right to request an accounting of disclosures of my protected health information;

___ ___ The right to communicate verbally regarding my appointments;

___ ___ The right to have verbal communication with my health care team;

___ ___ Other (please specify): _____

___ __ No expiration date

___ ___ Expires on _____ (date)

I understand that if I no longer wish for this Personal Representative designation to be in effect, I must deliver notice of revocation in writing to **ascoma Community Healthcare.** I also understand that it is my responsibility to notify my designee that I have revoked his or her access to my protected health information.

_____	_____	_____	_____
Printed Patient's Name	**Patient or Legal Guardian Signature**	Printed Legal Guardian Name	Date

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