Welcome to North Country Primary Care

- We are an NCQA-recognized Patient Centered Medical Home; see our brochure for details on this.

- We have a patient portal which allows you to access your personal health information 24 hours a day and 7 days a week. You can request appointments, prescription renewals as well as send email messages, saving you the time of making a phone call.

- If you take daily medications, please bring them with you to your appointments. The nurse will review your medications with you during your visit time.

- Call us first! We save time every day in our schedules for sick patients. Please let us know as early in the day as possible when you need our services so we can schedule you for a visit.

- Please call us as soon as possible when you’re unable to keep a scheduled appointment. This allows us to use that time for another patient.

- Please arrive on time for your appointment. This allows the nurse to complete the nursing portion of your visit and will allow you more time with your provider.

- We try to stay on schedule, but we also will spend whatever time is necessary to evaluate your problem and that puts us behind schedule at times.

- Co-payments are due at the time of your visit, unless prior arrangements have been made. Also, please bring your insurance card with you.

- Patients and staff can have allergies. Please don’t wear heavy perfumes or heavy scents as that might cause problems for others.

- If you are ill, please request a mask from our receptionist. This helps protect other patients and staff from getting sick with the same illness.

<table>
<thead>
<tr>
<th>Barton Orleans</th>
<th>Newport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic Hours</td>
<td>Clinic Hours</td>
</tr>
<tr>
<td>7:40 a.m. to 4 p.m.</td>
<td>7:30 a.m. to 4:15 p.m.</td>
</tr>
<tr>
<td>Phones</td>
<td>Phones</td>
</tr>
<tr>
<td>8 a.m. to 4:00 p.m.</td>
<td>8:00 a.m. to 4:00 p.m.</td>
</tr>
</tbody>
</table>

**Newport**

186 Medical Village Drive  
Newport, VT  05855  
Phone 802-334-3520  
Fax 802-334-3512

Option 1:  
Charles LaGay, DO  
Elizabeth Yasewicz, PA-C  
Megan Batchelder, MD  
Alexandra Peters, FNP

Option 2:  
Patrick Keith, MD  
Patrick Heaney, PA-C  
Rachel DiSanto, MD  
Rory Carr, FNP

Option 3:  
Umair Malik, MD  
Gally Hughes, FNP  
John Lippmann, MD  
Naomi Badger, FNP

Option 4:  
Maria Fatigati, MD

**Mental Health Services**  
Richard Edelstein, MD  
Kelly Hensley, DNP

**Long-term Care**  
Robert Hawkins, DO  
David Bourgeois, MD  
Megan Garrigan, PA-C  
Christie Aldrich, FNP  
Kirsten Grace, FNP

**Barton Orleans**  
488 Elm Street  
Barton, VT  05822  
Phone 802-525-3539  
Fax 802-525-3088
PATIENT REGISTRATION FORM
(Please print clearly)

LAST NAME: ______________________   FIRST NAME: ___________________ MI: _____   MAIDEN NAME: _______________________

DATE OF BIRTH: _________________________  SEX:  ____ MALE  ____ FEMALE

RACE: ___ American Indian or Alaskan Native ___ Asian ___ Black or African American ___ White ____ Refused to Report

ETHNICITY: ___ Hispanic or Latino ____ Non Hispanic or Latino ____ Refused to Report

Self-Identified Race/Ethnicity: _______________________________________  (Please specify)

LANGUAGE PREFERRED: _______________________________________  MARITAL STATUS:__________________________________

IF CHILD, PARENT(S)/LEGAL GUARDIAN(S) NAME:

MAILING ADDRESS:______________________________________________________________________________________

PHYSICAL (911) ADDRESS: ______________________________________________________________________________

TEMPORARY/SEASONAL ADDRESS (IF APPLICABLE): ____________________________________________________________

HOME PHONE: ______________________  WORK PHONE: ______________________ CELL PHONE: ___________________

PREFERRED METHOD TO CONTACT YOU: HOME WORK CELL OTHER: __________________________

EMAIL ADDRESS: _______________________________________________________________________________________

CAN WE SEND YOU AN INVITATION TO JOIN OUR PATIENT PORTAL, WHICH ALLOWS YOU TO ACCESS YOUR PERSONAL HEALTH
INFORMATION 24 HOURS A DAY, 7 DAYS A WEEK, REQUEST APPOINTMENTS, REQUEST PRESCRIPTION RENEWALS AND
SEND/RECEIVE SECURE MESSAGES?    ___________  YES     ___________  NO

NAME OF EMPLOYER: ____________________________________________ TELEPHONE: __________________________

PRIMARY INSURANCE: ______________________________ POLICYHOLDER: ______________________ DOB: ________

INSURANCE ID#: __________________________________GROUP#: ____________________________

SECONDARY INSURANCE: ______________________________ POLICYHOLDER: ______________________ DOB: ________

INSURANCE ID#: __________________________________GROUP#: ____________________________

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT FOR SERVICES NOT COVERED BY INSURANCE:

_________________________________________________ PHONE: __________________________

DO YOU HAVE A PREFERENCE FOR YOUR PRIMARY CARE PROVIDER? __________________________

Rev. 6/2020
New Patient Health Questionnaire

This is a confidential record. Information will not be released without your written permission.

Name: ____________________________________________ Date of Birth: ____________________

Local Pharmacy: _______________ Location: ____________ Mail Order Pharmacy: _______________

** Do you advance directives? _____ Durable power of attorney? _____ COLST: _______________
** If yes, please bring in a copy.

**Current Medical Problems**

Include current symptoms and active health problems

_________________________________________________________________________________  

_________________________________________________________________________________  

_________________________________________________________________________________

**Allergies**

Please list any allergies you may have to medications, pets, environmental, etc.

_______________________________________  ____________________________________  

_______________________________________  ____________________________________

**Immunizations**

Last Tetanus Booster ___________ Hepatitis B Series _________________  
Pneumonia Vaccine ____________ Influenza Vaccine(s) _______________

**Family Medical History**

<table>
<thead>
<tr>
<th>Relative</th>
<th>Age (or deceased)</th>
<th>Health Problems (or cause of death)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>_________________</td>
<td>____________________________________</td>
</tr>
<tr>
<td>Mother</td>
<td>_________________</td>
<td>____________________________________</td>
</tr>
<tr>
<td>Sister(s)</td>
<td>_________________</td>
<td>____________________________________</td>
</tr>
<tr>
<td>Brother(s)</td>
<td>_______________</td>
<td>____________________________________</td>
</tr>
</tbody>
</table>

What diseases run in your family? _______________________________________________________

__________________________________________________________________________________
Social History

Who lives at home with you? _______________________

Do you feel safe at home? ______ Have you been threatened or hurt? ________________________________

Have you every been physically, sexually or emotionally (verbally) abused? ___________________________

Are you sexually active? __________ What form of birth control do you use, if any? _____________________

Other sexual issues or concerns? _________________________________________________________________

<table>
<thead>
<tr>
<th>What is your gender?</th>
<th>What was your sex assigned at birth?</th>
<th>Do you identify as transgender or transsexual?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Female</td>
<td>□ Female</td>
<td>□ Yes</td>
</tr>
<tr>
<td>□ Male</td>
<td>□ Male</td>
<td>□ No</td>
</tr>
<tr>
<td>□ Genderqueer or not exclusively male or female</td>
<td>□ Male</td>
<td>□ Don’t know</td>
</tr>
</tbody>
</table>

Medications

List all medications with dose and frequency. Include non-prescription medications (aspirin, vitamins, etc.)

IMPORTANT: There are potential risks and side effects of long-term narcotic treatment. If you are currently taking a controlled substance, we cannot guarantee this will be continued once establishing with your new primary care provider. This will be determined once your new primary care provider has reviewed your records and assessed your current medical needs.

IMPORTANT: Also include any medications for opiate use disorder.

☐ Check here if no medications

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Health-Related Habits


Have you ever smoked? ______ What year did you quit? ______

Do you drink or have you ever drank alcohol? _____ What kind? ______

Number of drinks per week: ______

Do you use or have you ever used recreational drugs? _____ What kind(s)? ______

How often? ________________

Caffeine? ______ Coffee, tea, cola or other? ______ Amount per day: ________________

Do you follow a special diet? ______ What kind? __________________ Do you take calcium? ______

This is a confidential record. Information will not be shared without your written permission.
Protected Health Information Release Authorization

Full Name: ______________________ Date of Birth: ______________________

This will authorize ______________________ Phone: ______________________ City/State: ______________________

to disclose my protected health information to North Country Primary Care Newport / Barton Orleans as described for the following purpose:

Transfer of care/coordination of care / sharing care for seasonal residents / Other: ______________________

Dates of care include: _____________ to _____________ or _____ All dates or _____ as indicated below

Check all that apply:

☐ Discharge Summary (all within last 2 years)
☐ History & Physical
☐ Operative Note(s) (all within last 2 years)
☐ Consultation(s) (all within last 2 years)
☐ Progress Note(s) (all within last 2 years)
☐ X-Ray, Scans, etc. (all within last 2 years)
☐ All Records (exceptions noted below)

The information regarding the following areas of treatment will not be released without specific authorization, signed by my initials.

_____ Mental Illness (excluding psychotherapy notes)  _____ HIV related illness
_____ Drug or alcohol treatment *  _____ Hep C
_____ Opiate Use Disorder *

* Federal Confidentiality Law - 42 CFR Part 2 prohibits those receiving information on drug or alcohol treatment from re-disclosing it unless written consent is granted by the patient or otherwise permitted by 42 CFR Part 2.

- I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
- I understand that I MAY REFUSE TO SIGN THIS AUTHORIZATION. I also understand that North Country Hospital shall not refuse to treat me if I refuse to sign this authorization.
- I understand that this authorization may be revoked in writing and delivered to ______________ at any time, although the revocation will not be effective to previously released protected health information pursuant to a valid authorization.
- I understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and may no longer be protected by federal rules.
- I understand that North Country Hospital shall have the opportunity to obtain compensation in the nature of

_____ from ______________ as a result of this authorization.
(describe) (third party)

__________________________  ____________________________
Date  Signature of individual or representative

Authority or relationship of representative
(attach copy of documentation of authority)

EXPIRATION DATE: This authorization will expire on (no later than one year from today) ______________ (if no date is stated, this authorization expires six months from the date it was signed.)
COPY PROVIDED: The patient will be provided a copy of this authorization.
TO THE RECIPIENT OF THIS AUTHORIZATION AND INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal law. This authorization does not permit further disclosure without patient authorization.
AUTHORITY: This form is designed to comply with CFR 45 Sec. 164.508, regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Rev 11.2019