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>
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<tbody>
<tr>
<td>Clinic Hours</td>
<td>8 a.m. to 5 p.m.</td>
</tr>
<tr>
<td>Phones</td>
<td>8 a.m. to 4:30 p.m.</td>
</tr>
<tr>
<td></td>
<td>Monday - Friday</td>
</tr>
</tbody>
</table>

| Clinic Hours   | 7:20 a.m. to 6 p.m. |
|Phones         | 8 a.m. to 4:45 |
|                | Tuesday |

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11/2019
PATIENT REGISTRATION FORM

(Please print clearly)

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

DATE OF BIRTH: _________________________  SEX:  ____ MALE  ____ FEMALE   SOC. SEC.#: ______________________________

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:
_____________________________________________________________________

RELATIONSHIP: ________________________

MAILING ADDRESS: ______________________________________________________________________________________________

PHYSICAL (911) ADDRESS: _________________________________________________________________________________________

TEMPORARY/SEASONAL ADDRESS (IF APPLICABLE): _____________________________________________

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. 12/2016
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 have 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 ever 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? ________________________________________________________________

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 made an assessment of 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)
- Laboratory Data (all within last 2 years)
- E.R. Record(s) (all within last 2 years)
- E.K.G. (s) (all within last 2 years)
- Nurses Note(s)
- Other: Problem list, Medications, Allergies

The information regarding the following areas of treatment will not be released without specific authorization,
signified 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