Thank you for requesting care at North Country Primary Care in our Newport or our Barton Orleans location. Currently, we have limited access for accepting new patients.

- If you already have a PCP, we will ask for the time being you remain with that office and give us a call back in 6 months to see if we’re accepting transfers from other offices.

- If you live outside our service area (Orleans and Northern Essex County), reach out to local primary care providers in your area.

All other patients, please complete the attached North Country Primary Care new patient packet, return it to us and if we can accommodate your medical needs, we will mail you a letter with our earliest available appointment with your new provider.

In keeping with our current practice, new pediatric patients, without a current Primary Care Provider, will be accepted in both locations or you can reach out to North Country Pediatrics at 334-3529 to establish care for your child.

Thank you for your understanding.

The staff at North Country Primary Care
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><strong>Clinic Hours</strong></td>
<td><strong>Clinic Hours</strong></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>Monday - Friday</td>
<td>Monday - Friday</td>
</tr>
<tr>
<td><strong>Phones</strong></td>
<td><strong>Phones</strong></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>
<tr>
<td>Monday – Friday</td>
<td>Monday – Friday</td>
</tr>
</tbody>
</table>

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

**Mental Health Services**
Richard Edelstein, MD
Kelly Hensley, DNP
Phone: 802-334-3526

**Option 1:**
Charles LaGoy, 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
Cally Hughes, FNP
John Lippmann, MD
Naomi Badger, FNP

**Option 4:**
Maria Fatigati, MD

**Barton Orleans**
488 Elm Street
Barton, VT 05822
Phone 802-525-3539
Fax 802-525-3088

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

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? ________________________________
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 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? __________________________________________________________

<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) ☑ Laboratory Data (all within last 2 years)
☒ History & Physical ☑ E.R. Record(s) (all within last 2 years)
☒ Operative Note(s) (all within last 2 years) ☑ E.K.G. (s) (all within last 2 years)
☒ Consultation(s) (all within last 2 years) ☑ Nurses Note(s)
☒ Progress Note(s) (all within last 2 years) ☑ Other: Problem list, Medications, Allergies
☒ 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 ______________ (third party) as a result of this authorization.

_________________________ ____________________________
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).