New Patient Welcome Packet

Please fill out and return to CHCFC

Greenfield Medical & Dental
102 Main Street
Greenfield, MA 01301
Tel: (413) 325 - 8500

Urgent Dental Care
164 High Street
Greenfield, MA 01301
Tel: (413) 325 - 8700

Orange Medical & Dental
450 W River Street
Orange, MA 01364
Tel: (978) 544 - 7800
WELCOME TO THE COMMUNITY HEALTH CENTER OF FRANKLIN COUNTY!

I am so glad you are here. CHCFC is not just a “regular” doctor’s office. We are proud to do things a little differently. We are a nonprofit organization, which means we are driven by mission instead of by profit. No one owns this company, because it belongs to the entire community. It belongs to you.

We strive to deliver high quality healthcare to all of our community members with respect, not judgment. No one should be left out. As a Federally Qualified Health Center (FQHC) we have quality control programs and a Board of Directors made up of community members, the majority of whom are patients here. If you are interested in applying to serve on the Board, please let us know by emailing info@chcfc.org.

At CHCFC, we are here for you if you’re sick, but we also want to help you achieve your best health. We are located in Greenfield and in Orange, and we offer a variety of services including dental, medical, behavioral health, pediatrics, addiction, and sexual and reproductive health care. Good health sometimes means medicine, but it can also mean social connection, a ride to your appointment, a safe environment, help with your insurance, exercise, nutritious foods, a language interpreter, and so much more. As a patient of the Health Center, you have access to resources and programs that support your whole health. Please let us know what you need, so we can connect you.

Choosing an FQHC office like ours means receiving patient-centered healthcare- and it comes with the best side effect: when we serve you, you are supporting your community health center.

Let us know if you have any questions, concerns, or suggestions. It is a privilege to be your healthcare partner.

Sincerely,

Allison van der Velden
CEO

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2020 REGISTRATION FORM

Office/Service(s) Registering For:
☐ Greenfield Dental  ☐ Greenfield Medical  ☐ Behavioral Health  ☐ Orange Dental  ☐ Orange Medical

Patient Information
Last Name: ___________________________
First Name: ___________________ MI: ______
Preferred Name: ___________________
Preferred Pronouns: ___________________
Mailing Address: ____________________________
City: __________________ State: ______ Zip: ______
Home Phone: _______________________
Work Phone: _______________________
Cell Phone: _______________________
Date of Birth: ___________ SSN: ___________
Marital Status: _______________________
Emergency Contact: ____________________________
Address: ___________________________
City: ___________ State: ______ Zip: ______
Relationship: _______________________
Emergency Phone: _______________________
Pharmacy: _______________________

Sexual Orientation & Gender Identity (SOGI)
What sex were you assigned at birth?
☐ Male  ☐ Female
What is your current gender identity?
☐ Male  ☐ Female  ☐ Gender Queer
☐ Transgender Male  ☐ Transgender Female
☐ Other please specify: ___________________
☐ Choose not to disclose
Do you think of yourself as:
☐ Lesbian, gay, or homosexual
☐ Straight or heterosexual
☐ Bisexual  ☐ Something Else
☐ Don’t know  ☐ Choose not to disclose
Do you identify as Transgender or Transsexual?
☐ Yes  ☐ No

Race & Ethnicity
Are you Hispanic/Latino?  ☐ Yes  ☐ No
What is your Race (check all that apply):
☐ Asian  ☐ Native Hawaiian/Pacific Islander
☐ Black/African American  ☐ White/Caucasian
☐ American Indian or Alaska Native

Insurance and Payment
Who is responsible for payment (Guarantor)
Name: ____________________________
Address: ____________________________
City: ___________ State: ______ Zip: ______
DOB: ___________ SSN: ___________
Relationship: _______________________
Do you have Medical Insurance?  ☐ Yes  ☐ No
Primary Plan: _______________________
Secondary Plan: _______________________
Do you have Dental Insurance?  ☐ Yes  ☐ No
Primary Plan: _______________________

Family Income & Patient Employment/Student Status
Family Size: ___________ Adults: ______ Children: ______
Household Estimated Yearly Income:
☐ <$10,000  ☐ $10-$20,999  ☐ $21-$30,999
☐ $31-$40,999  ☐ $41-$50,999  ☐ $51-$60,999
If over $70,000 enter here: _______________________
Are you employed?  ☐ Full time  ☐ Part Time
☐ Retired  ☐ Disabled  ☐ Student  ☐ Unemployed
Occupation: _______________________
Employer/School: _______________________

Language
Do you speak English?  ☐ Yes  ☐ No  ☐ Some
Do you need a translator?  ☐ Yes  ☐ No
What is your preferred language? _______________________

Additional Services (check all that apply):
☐ Veteran  ☐ Homeless
☐ Farmworker (If so, please select one below)
☐ Full Time  ☐ Seasonal  ☐ Migrant
Do you have transportation?  ☐ Yes  ☐ No

How did you hear about us?
☐ Friend or Family  ☐ Agency Referral
☐ Newspaper  ☐ Facebook  ☐ Community Event
☐ Other: _______________________

Consent and Release:
I hereby authorize the Community Health Center of Franklin County to provide treatment as necessary for me and my family, including emergency care if necessary. I also authorize release of all necessary information to my insurance company, payer, and/or medical/dental provider for the purpose of payment or providing continuing treatment. I assign the Community Health Center of Franklin County to claim and collect insurance benefits payable for its treatment of me and my family. I understand that I may be responsible for payment of any service not covered by insurance or other benefits, including claims occurring under accident coverage such as workers compensation or automobile insurance. I understand that my insurer may require me to have a CHCFC provider designated as my PCP to have my medical visits covered.

Signature of patient or parent/legal guardian: ____________________________ Date: ___________
PERMISSION TO RELEASE PATIENT INFORMATION

We will not give information out to anyone unless their name(s) is written below and signed by you. This release of information does not include record requests to/from other doctor's offices, requests by insurance companies or other outside agencies. You must fill out specific releases for these purposes.

Patient Name: __________________________ Date of Birth: __________________________

1. I hereby give permission to the Community Health Center of Franklin County release the following to those listed below:

☐ Written prescriptions or medications
☐ Pick up or discuss test results or test requisitions (i.e. lab slips)
☐ Dental x-rays
☐ Discuss specialist referrals or appointments
☐ Verify or change my appointment at the health center
☐ Discuss dental treatment
☐ School nurse, Principal, Psychologist (school-related)

Relationship: __________________________
Relationship: __________________________
Relationship: __________________________

~ OR ~

2. I do not allow any information about me released to anyone: ☐

PLEASE SIGN BELOW

Patient/Guardian signature: __________________________ Date: __________________________
Medical & Dental Health History

Name: ___________________________ Date of Birth: ___________________________

Date of last physical exam: ___________________________ Date of last dental exam: ___________________________

Previous Provider: ___________________________ Previous Dentist: ___________________________

City, State: ___________________________ City, State: ___________________________

Previous Pharmacy: ___________________________

Allergies (including medication, food, and environmental) OR □ No Known Allergies

_________________________________________________________

Current Medications (including vitamins, supplements, and birth control) Please list name, dose, and frequency.

_________________________________________________________

_________________________________________________________

Please answer these questions as best you can by checking one of the following boxes, "Yes", "No", "NS" (Not Sure). Your answers are confidential and for our records only.

- Have you ever taken medications or received an IV to treat osteoporosis or bone issues (bisphosphonate drugs: Fosamax, Boniva, etc.)? □ Yes □ No □ NS
- Have you ever been hospitalized? □ Yes □ No □ NS
  - If yes, for what? ___________________________
- Have you had surgery? □ Yes □ No □ NS
  - If yes, what surgery and when? ___________________________
- When was your last tetanus shot? ___________________________ Where? ___________________________
- Have you had a colonoscopy? □ Yes □ No □ NS
  - If yes, when and where? ___________________________
- Have you had a pap smear? □ Yes □ No □ NS
  - If yes, when and where? ___________________________
- Have you ever had a mammogram? □ Yes □ No □ NS
  - If yes, when and where? ___________________________
- Are you pregnant? □ Yes □ No □ NS
- Would you or your partner like to become pregnant in the next year? □ Yes □ No □ NS
- Are you currently breastfeeding? □ Yes □ No □ NS
- Do you or have you ever had exposure to hazardous material? □ Yes □ No □ NS
  - If yes, what material(s)? ___________________________
- Do you use tobacco products or vape? □ Yes □ No □ NS
- If yes, what type and how often?__________________________________________
- Do you exercise?☐ Yes ☐ No ☐ NS
  - If yes, what kind and how often?__________________________________________
- Are you on any special diet?☐ Yes ☐ No ☐ NS
  - If yes, type?__________________________________________
- Do you see a specialist for a medical condition?☐ Yes ☐ No ☐ NS
  - If yes, name and specialty?__________________________________________

Please check the boxes below that apply to your health history.

<table>
<thead>
<tr>
<th>Heart/Blood Problems</th>
<th>Stomach/Intestine Problems</th>
<th>Mouth/Teeth Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ NONE</td>
<td>☐ NONE</td>
<td>☐ NONE</td>
</tr>
<tr>
<td>☐ Angina (chest pain)</td>
<td>☐ Crohn’s disease</td>
<td>☐ Bleeding gums</td>
</tr>
<tr>
<td>☐ Congenital defect</td>
<td>☐ GERD (heartburn / acid reflux)</td>
<td>☐ Clenching/grinding</td>
</tr>
<tr>
<td>☐ Endocarditis</td>
<td>☐ Hepatitis: A B C</td>
<td>☐ Difficulty chewing</td>
</tr>
<tr>
<td>☐ Anemia</td>
<td>☐ Irritable bowel syndrome</td>
<td>☐ Difficulty swallowing</td>
</tr>
<tr>
<td>☐ Heart attack</td>
<td>☐ Jaundice</td>
<td>☐ Jaw pain</td>
</tr>
<tr>
<td>☐ Heart surgery</td>
<td>☐ Stomach ulcers</td>
<td>☐ Pain/Swallowing</td>
</tr>
<tr>
<td>☐ High blood pressure</td>
<td>☐ Ulcerative colitis</td>
<td>☐ Sensitivity</td>
</tr>
<tr>
<td>☐ Mitral valve prolapse</td>
<td></td>
<td>☐ Sores in mouth</td>
</tr>
<tr>
<td>☐ Murmур</td>
<td>☐ Other:____________________</td>
<td>☐ Other:________________</td>
</tr>
<tr>
<td>☐ Pacemaker</td>
<td></td>
<td></td>
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<tr>
<td>☐ Stroke: ___________ (date)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Other:______________</td>
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<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Bone/Muscle Problems</th>
<th>Endocrine Problems</th>
<th>Lung Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ NONE</td>
<td>☐ NONE</td>
<td>☐ NONE</td>
</tr>
<tr>
<td>☐ Chronic pain</td>
<td>☐ Diabetes: TYPE 1 TYPE 2</td>
<td>☐ Asthma</td>
</tr>
<tr>
<td>☐ Joint replacement: (which joint/when) ____________</td>
<td>☐ Overactive Thyroid (hyperthyroidism)</td>
<td>☐ COPD</td>
</tr>
<tr>
<td></td>
<td>☐ Osteoarthritis</td>
<td>☐ Cough with blood</td>
</tr>
<tr>
<td></td>
<td>☐ Rheumatoid arthritis</td>
<td>☐ Persistent cough</td>
</tr>
<tr>
<td></td>
<td>☐ TMJ Disorder</td>
<td>☐ Shortness of breath</td>
</tr>
<tr>
<td></td>
<td>☐ Other:___________</td>
<td>☐ Tuberculosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Other:__________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual Health History</th>
<th>Mental Health History</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following questions are personal but are important in helping us give you the best care.</td>
<td>☐ Anxiety</td>
<td>☐ Glaucoma</td>
</tr>
<tr>
<td>☐ I have been sexually active in the past</td>
<td>☐ Bipolar disorder</td>
<td>☐ Kidney problems</td>
</tr>
<tr>
<td>☐ I am currently sexually active</td>
<td>☐ Depression</td>
<td>☐ HIV/AIDS</td>
</tr>
<tr>
<td>☐ I have had more than one partner in the past</td>
<td>☐ PTSD</td>
<td>☐ History of seizure</td>
</tr>
<tr>
<td>☐ I have been forced or pressured into sexual activity</td>
<td>☐ Other:________________</td>
<td>☐ Cancer (type): ______________</td>
</tr>
<tr>
<td>☐ Any other condition or problem(s):</td>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

Signature:__________________________________________ Date:__________________________
Reviewed By (Provider Signature):__________________________
# Community Health Center of Franklin County

## Patient Consent for Health Information Exchange

### PATIENT INFORMATION (Please Print Clearly)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>Medical/Dental Record Number</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Address: City, State, Zip Code</th>
</tr>
</thead>
</table>

### PATIENT CONSENT FOR HEALTH INFORMATION EXCHANGE

By agreeing to **GIVE CONSENT** below, I hereby authorize any of the parties designated on the next page to communicate with one another about me verbally, in writing, or via electronic information exchange. Such communication may include requesting, receiving, providing, and using my medical/dental information. I understand that the purpose of communicating about me is to allow the parties to evaluate my needs, provide services to me, and coordinate my care. I further understand that I may be required to sign additional consent forms to be eligible for insurance coverage and payments or certain types of treatments and services.

I understand that my medical/dental information will include all pertinent information from my medical/dental record as described here:

- My name and other personal identifying information.
- My identity as an applicant for or recipient of healthcare services, which may include substance use disorder and/or mental health services.
- The contents of my medical/dental record, which may include:
  - Problems/diagnoses.
  - Visit/discharge/examination assessments and summaries.
  - Laboratory/x-ray tests and results.
  - Medications.
  - Procedures.
  - Family/social history.
  - Other information about my health.
- My medical/dental record may include information about the following conditions and treatment:
  - Mental health.
  - Substance use disorder.
  - Sexually transmitted diseases.
  - Pregnancies/abortions.
  - Domestic abuse.
  - Rape/sexual assault.
  - Genetic diseases, testing, and test results.
  - Mammograms.
  - Other information about my health.

I understand I have the right to exclude certain types of health information from being exchanged. I exclude the following:

I understand that certain federal laws, including the Health Information Portability and Accountability Act (HIPAA), allow providers and other healthcare organizations to exchange much of my health information without my consent in order to provide me with treatment, receive payment for my care, and manage and coordinate my care. I further understand that my healthcare providers are permitted or required by law to provide some of my medical/dental information without my consent to other healthcare providers, public health agencies, and law enforcement for purposes including but not limited to medical/dental emergencies, quality reporting, audits, crimes against persons and property, and certain legal orders. I understand that Community Health Center of Franklin County is not responsible for authorized or unauthorized re-disclosure of my health information by receiving providers.
Community Health Center of Franklin County
Patient Consent for Health Information Exchange

PATIENT CONSENT FOR HEALTH INFORMATION EXCHANGE (Continued)
I understand that the following healthcare providers, including their staff, employees, and contracted entities, may provide or receive my medical/dental information for the purposes of evaluating my needs, providing services to me, and coordinating my care. I understand that only the providers who need to coordinate a particular aspect of my care will provide or receive information about that aspect of my care.

☐ Transferring Records to CHFC
☐ Transferring Records from CHFC

☐ List specific provider(s) / practice(s)
Attach additional sheets if needed

Records to be Disclosed:
☐ Medical
☐ Dental
☐ Other:

Type of Records:
☐ Entire record
☐ Immunizations only
☐ Other:

Period of Information:
☐ Entire period of care

CHCFC OFFICE USE ONLY:
☐ CHD
☐ BFML
☐ ATH/HWH

☐ General designation
I understand that any of my treating providers may provide or receive my medical/dental information for treatment purposes. I understand that I have a right to obtain, upon request, a list of entities to whom my medical/dental information has been disclosed (List of Disclosures), pursuant to the general designation.

☐ I give permission to share information from my medical/dental record about HIV antibody and antigen testing with:

Print name of facility and provider

I give permission to share information from my medical/dental record about HIV antibody and antigen testing with:

Patient Initials
Date

I understand that my healthcare providers may communicate my information by any means, including verbally, by paper, by fax, by secure electronic transmissions, and by the Massachusetts Health Information Highway (the Mass Hlway).

MY CONSENT CHOICE
I understand that I have the right to receive a copy of this consent form.

☐ I GIVE CONSENT. By my signature below, I acknowledge that I have given my consent as indicated above freely, voluntarily, and without coercion. I understand that I have the right to revoke this consent at any time; however, any information that was already exchanged cannot be taken back. If I have not revoked this consent, it will expire when one of the following conditions is satisfied. Choose one:

☐ Consent expires one year after the Effective Date of this consent (below)
☐ Consent expires on this date: __________________________
☐ Consent expires upon this condition or event:

☐ I DENY CONSENT. By my signature below, I acknowledge that I have denied consent for my healthcare providers to communicate my health information to one another. I acknowledge that by denying my consent, my healthcare providers may have limits on their ability to provide and coordinate my care.

___________________________
Signature of Patient

__________
Effective Date

___________________________
Signature of Patient’s Legal Guardian or Authorized Representative

__________
Effective Date

___________________________
Print Name of Legal Guardian or Authorized Representative

___________________________
Signature of Translator (if applicable)

___________________________
Printed Name of Translator (if applicable)
ELECTRONIC COMMUNICATIONS AUTHORIZATION

Please review the following practices that the health center uses to communicate with you electronically. Your signing this form and providing us with your email and/or phone number, constitutes acceptance of and your acknowledgement of these communication practices. If you would rather not have us communicate using phone or text, please be sure to check the NO box to the right of each box.

E-Mail Address: ________________________ @ ________________________

□ NO, I do not wish to be contacted via e-mail at this time.

WE WILL CONTACT YOU BY EMAIL, including but not limited to: appointment reminders, medication refills, care coordination, other Health Center publications, and messaging to support access to my secure patient chart online. I understand regular e-mail is insecure in transit over the internet, and so all e-mail communications from the Health Center to me that contain protected health information (PHI) will be encrypted unless I specifically request otherwise.

Text Message (SMS): ( _______ ) _________ - ________

□ NO, I do not wish to be contacted via text message at this time.

YOU MAY RECEIVE TEXT MESSAGES FROM US, including but not limited to: appointment reminders, medication refills, care coordination, other Health Center publications, and messaging to support access to my secure patient chart online. I understand the receipt of text messages may incur additional charges from my texting provider, and I am solely responsible for this expense. I understand text messages may be insecure in transit, and so messages from the Health Center to me will not contain protected health information (PHI), unless I specifically request otherwise.

Health Information Exchange (HIE)

□ NO, I object to the use of secure electronic communications using HIE technologies at this time. I understand this preference limits my clinical team to the use of inefficient fax and paper records for coordination of my care with other health care providers, including in the event of a medical emergency.

WE WILL UTILIZE ALL AVAILABLE TECHNOLOGIES for the secure and efficient coordination of my care with my other health care providers and community-based organizations, including but not limited to the Massachusetts Health Information Highway (Mass HIway), Pioneer Valley Information Exchange (PVIX), electronic referrals (e-Referral), and electronic prescription history synchronization (RxHiX).

This authorization is effective as of the date indicated below. I understand I may modify these communication preferences at any time. Please allow 48 business hours for processing.

Patient Name (Print) ________________________

Signature of Patient, Parent or Guardian ________________________

Date ________________________

Relationship to Patient (if applicable) ________________________

OFFICE USE ONLY:

MRN: ___________ RCVD ___ / ___ / ___ □ ORIGINAL □ REVISED □ PM UPDATED ______