Community Health Connections

We take great care of you!

MEDICAL PATIENT REGISTRATION FORM

Today's Date:_____

How did you learn about us? ☐Website ☐Bus ad ☐Event ☐Family/friend ☐Word of mouth ☐Other_____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Street Address: _____

City, State, Zip: _____

Social Security Number: _____Home telephone:_____

Work telephone: _____Cell Telephone: _____

Email Address: _____

PRIMARY CARE PROVIDER PREFERENCE ☐**SUBSTANCE TREATMENT ONLY** **PRIMARY CARE PROVIDER:** _____

I prefer a ☐Male ☐Female ☐I have no preference.

(Optional) Explain other preferences such as age of provider, experience with certain conditions, etc.

_____

_____

_____

LOCATION I would like to be seen at:

☐ Fitchburg CHC	326 Nichols Rd., Fitchburg	☐ Gardner CHC	175 Connors St., Gardner
☐ Leominster CHC	165 Mill Street, Leominster	☐ ACTION CHC	130 Water St., Fitchburg

HEALTH INSURANCE INFORMATION

Do you have health insurance? ☐ Yes ☐ No

Name of health insurance company:_____

Subscriber: _____ ID#: _____

EMERGENCY CONTACT

Name: _____ Phone number: _____

Relationship: _____

Do you have a health care proxy? ☐ Yes (please complete the healthcare proxy form attached) ☐ No

Do you regularly receive medical or psychiatric care form another provider? ☐ Yes ☐ No

If yes, with whom: _____

_____

_____

I have completed this form and certify that I am the patient or the duly authorized agent of the patient. I understand that I am responsible for payment of services that my insurance does not cover.

SIGNATURE: _____ DATE: _____

HEALTH QUESTIONAIRE

Please fill out completely

Name: _____ **Date of Birth:** _____

ALLERGIES to MEDICATION

MEDICATION	REACTION TO MEDICATION	YEAR

IMMUNIZATIONS (Please provide copies of your vaccine records)

IF YOU HAD CHICKEN POX, WHEN?	
DATE OF LAST TETANUS VACCINE:	
DATE OF LAST PHEUMONIA VACCINE:	
DATE OF LAST FLU VACCINE:	

PLEASE LIST ALL MEDICATIONS YOU TAKE (include over the counter medication)

NAME OF MEDICATION	STRENGTH	HOW OFTEN TAKEN

PLEASE LIST ANY SURGERIES AND SERIOUS ILLNESS

SURGERY / ILLNESS	YEAR	HOSPITAL AND STATE

Name: _____ **Date of Birth:** _____

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

ANEMIA	BREAST CANCER
ATRIAL FIBRILLATION	CVA (STROKE)
HYPERTENSION (HIGH BLOOD PRESSURE)	HYPERCHOLESTEROL (HIGH CHOLESTEROL)
HEART ATTACK	HEART VALVE PROBLEM
HYPOTHYROIDISM (UNDERACTIVE THEYROID)	JUVENILE DIABETES
ADULT ONSET DIABETES (NO INSULIN USED)	ADULT ONSET DIABETES (INSULIN USE)
ASTHMA	COPD
EMPHYSEMA	POST TRAUMARIC STRESS DISORDER (PTSD)
BIPOLAR DISORDER	DEPRESSION
ALLERGIC RHINITIS (ALLERGIES)	HEPATITIS C
HIV	

PLEASE LIST ANY SIGNIFICANT FAMILY ILLNESS BELOW

FAMILY MEMBER	ILLNESS	ALIVE OR DECEASED

HABITS

☐Never a smoker ☐Former smoker ☐Current smoker # of cigarettes per day_____

☐Do not drink alcohol ☐Drink alcohol How often? ☐Daily ☐Weekly ☐Monthly ☐A few times a year

What is the average number of drinks you consume when you drink? _____

☐Do not use street drugs ☐Use street drugs Type/How often_____