CHCFC
Community Health Center of Franklin County

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
119 New Athol Road
Orange, MA 01364

Tel: (978) 544 - 7800

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of Franklin County

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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Patient Registration Form

Date: _____

Please register me for:	☐ Medical Services	☐ Dental Services	☐ Behavioral Health Services
Location:	☐ Greenfield	☐ Orange	☐ Baystate (Urgent Dental Only)

Patient Information

Today's Date: _____

Legal Name (First & Last): _____

Preferred/Current Name: _____ Pronouns: _____

Sex Assigned at Birth*: ☐ Female ☐ Male ☐ Non-Binary ☐ Other ☐ Unknown ☐ X

**While CHCFC recognizes a number of genders/sexes, many insurance companies and legal entities do not. Please know that we are required to use the name and sex listed on your insurance for documents related to insurance, billing and correspondence. During your visit and everywhere else we'll use your current name and pronouns.*

Date of Birth: _____ SSN: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone 1: _____ ☐ Cell ☐ Home ☐ Work

Phone 2: _____ ☐ Cell ☐ Home ☐ Work

Email Address: _____

*All parents with custodial rights information should fill out the information below.

Parent/Guardian Name (if applicable): _____

Parent/Guardian Name (if applicable): _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Preferred Pharmacy: _____

Insurance and Payment Information

Do you have Medical Insurance? ☐ Yes ☐ No

Name of Policy Holder: _____ Date of Birth: _____

Phone #_____ Address_____ Employment Status_____

Relationship to Policy Holder: _____

Primary Plan: _____ Policy/ID Number: _____

Secondary Plan:_____ Policy/ID Number: _____

Do you have Dental Insurance? ☐ Yes ☐ No

Primary Plan: _____ Policy/ID Number: _____

Secondary Plan:_____ Policy/ID Number: _____

Would you like to apply for our sliding fee scale? ☐ Yes

Would you like help with insurance enrollment? ☐ Yes

Turn Over!

Ethnicity

☐ Hispanic/Latino/Latinx ☐ Puerto Rican
☐ Non-Hispanic ☐ Cuban
☐ Mexican/Mexican American ☐ Declined
☐ Other, please specify: _____

Race (select one or more)

☐ Black or African American
☐ White ☐ American Indian or Alaska Native
☐ Asian ☐ Native Hawaiian or Pacific Islander
☐ Declined ☐ Some other Race

Marital Status

☐ Married/Partnered
☐ Single
☐ Divorced
☐ Legally Separated
☐ Widowed
☐ Child
☐ Significant Other
☐ Domestic Partner

Gender Identity

☐ Female ☐ Male ☐ Intersex ☐ Non-Binary
☐ Transgender Male (FTM)
☐ Transgender Female (MTF)
☐ Genderqueer, neither exclusively male nor female
☐ Other, please specify: _____
☐ Choose not to disclose

Religion

_____

Public Housing

☐ Yes ☐ No

Sexual Orientation

☐ Lesbian, gay, or homosexual
☐ Straight or heterosexual
☐ Bisexual
☐ Something else, please describe: _____
☐ Don't know
☐ Choose not to disclose

Family Financial Information

Family/Household Size: _____
Income $_____

☐ Weekly ☐ Monthly
☐ Bi-weekly ☐ Annually
☐ Salary ☐ Pension
☐ Gov. Assistance ☐ Social Security

Language

Primary Language/Written Language

_____

Would you like a translator for your appointment? ☐ Yes ☐ No

Employed In Healthcare?

☐ Yes ☐ No

Resident in Congregate Housing?

☐ Yes ☐ No

Work & Housing

What is your employment status?

☐ Employed ☐ Disabled
☐ Self Employed ☐ Full Time Student
☐ Unemployed ☐ Part Time Student
☐ Retired

Employer_____

Are you a CHCFC employee? ☐ Yes ☐ No

Are you a farmworker? ☐ Yes ☐ No
If yes, what is your status?
☐ Seasonal
☐ Migrant

Are you currently homeless? ☐ Yes ☐ No
Are you a veteran? ☐ Yes ☐ No
Branch_____

Transportation

Do you need help with transportation to your appointments? ☐ Yes ☐ No

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.

X_____

Signature of patient or parent/legal guardian **Date**

Staff Initials: _____

Created: 4/2021 Updated: 3/2024

CHCFC
Community Health Center of Franklin County

Date: _____

Release of Information

Please complete this form if you would like us to share any information about your care with a family member, friend, or other caregiver.

Please check the box at the bottom of the page if you would not like to share information about your care.

Name: _____ Date of Birth: _____

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

☐ Discuss all medical treatment

☐ Discuss all dental treatment

☐ Make, verify, or change an appointment at the Health Center

☐ Request refills or discuss prescription medications

☐ Pick up or discuss test results

☐ Pick up or discuss dental x-rays

☐ Pick up or discuss forms (school or camp forms, return to work letters, lab orders, etc.)

☐ Discuss specialist referrals or appointments

☐ Other (please specify): _____

Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship

_____

☐ I do not allow any release of medical or dental information.

Patient/Parent or Guardian Signature: _____ Date: _____

Updated: 2/2022

Left blank intentionally. Please proceed to next page.

CHCFC
Community Health Center of Franklin County

Medical & Dental Health History

Today's Date: _____

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.

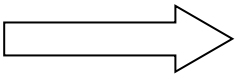
_____ _____

_____ _____

_____ _____

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.

Heart/Blood Problems	Stomach/Intestine Problems	Mouth/Teeth Problems
☐ **NONE** ☐ Angina (chest pain) ☐ Congenital defect ☐ Endocarditis ☐ Anemia ☐ Heart attack_____(date) ☐ Heart surgery _____(date) ☐ High blood pressure ☐ Mitral valve prolapse ☐ Murmur ☐ Pacemaker ☐ Stroke: _____(date) ☐ Other:_____	☐ **NONE** ☐ Crohn's disease ☐ GERD (heartburn / acid reflux) ☐ Hepatitis: A B C ☐ Irritable bowel syndrome ☐ Jaundice ☐ Stomach ulcers ☐ Ulcerative colitis ☐ Other:_____ _____	☐ **NONE** ☐ Bleeding gums ☐ Clenching/grinding ☐ Difficulty chewing ☐ Difficulty swallowing ☐ Jaw pain ☐ Pain/Swelling ☐ Sensitivity ☐ Sores in mouth ☐ Other:_____ _____
Bone/Muscle Problems	**Endocrine Problems**	**Lung Problems**
☐ **NONE** ☐ Chronic pain ☐ Joint replacement: (which joint/when) _____ ☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ TMJ Disorder ☐ Other:_____ _____	☐ **NONE** ☐ Diabetes: TYPE 1 TYPE 2 ☐ Overactive Thyroid (hyperthyroidism) ☐ Underactive Thyroid (hypothyroidism) ☐ Other:_____ _____	☐ **NONE** ☐ Asthma ☐ COPD ☐ Cough with blood ☐ Persistent cough ☐ Shortness of breath ☐ Tuberculosis ☐ Other:_____ _____
Sexual Health History *The following questions are personal but are important in helping us give you the best care.* ☐ I have been sexually active in the past ☐ I am currently sexually active ☐ I have had more than one partner in the past year ☐ I have been forced or pressured into sexual activity	**Mental Health History** ☐ **NONE** ☐ Anxiety ☐ Bipolar disorder ☐ Depression ☐ PTSD ☐ Other:_____ _____	**Other** ☐ Glaucoma ☐ Kidney problems ☐ HIV/AIDS ☐ History of seizure ☐ Cancer (type): _____ _____ ☐ Any other condition or problem(s): _____ _____

Signature: _____ Date:_____

Reviewed By (Provider Signature):_____

Medical & Dental: 119 New Athol Rd, Orange, MA 01364
Phone: (978) 544-7800 ● Fax: (978) 544-0023

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Patient Consent for Health Information Exchange

PATIENT INFORMATION (Please Print Clearly)

Last Name	First Name	Middle Initial

Date of Birth (mm/dd/yyyy)	Medical/Dental Record Number	Phone Number

Home Address: City, State, Zip Code

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.

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 CHCFC** ☐ **Transferring Records from CHCFC**

☐ List specific provider(s) / practice(s) *Attach additional sheets if needed* _____ _____ Prior PCP **(Incoming Records Only):** _____	**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** ☐ **BFMC** ☐ **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 *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 HIway).

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 **Description of Authority** *if signed by Legal Guardian or Authorized Representative*

_____ _____

Signature of Translator (if applicable) **Printed Name of Translator (if applicable)**

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Community Health Center of Franklin County

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: _____ @ _____ . _____

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

Text Message (SMS): (_____) _____ - _____

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

Health Information Exchange (HIE)

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 (RxHx).	☐ 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 my other health care providers, including in the event of a medical emergency.

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)