



GLACIER COMMUNITY HEALTH CENTER

New Patient Registration Demographic Information

Patient's Name: (Last, First, MI, Maiden Name)			Current Doctor:		
Mailing Address:			City, State, Zip		
Date of Birth: / /		Age:	Social Security #: - -		Marital Status (circle one): Single / Mar / Div / Sep / Wid
Home phone: () - OK to leave message? ☐ Yes ☐ No			Cell phone: () - OK to leave message? ☐ Yes ☐ No		
Sex Assigned at Birth (circle one): M F		Sexual Orientation (circle one): Straight / Lesbian/Gay / Bisexual / Other / Unknown			
Gender Identity (circle one): M F Female to Male FTM Male to Female MTF Genderqueer Decline Other _____					
Pronouns (circle one): he/him/his she/her/her other _____			Email: Have you ever been a member of the armed forces? ☐ Yes ☐ No		
Race (circle one): Asian African-American Native American White More than 1 race					
Ethnicity (circle one): Hispanic Not Hispanic			Language Preferred (circle one): English Spanish Other _____		
Occupation: _____ Employer: _____			Work Phone: () - OK to leave message: Yes ☐ No ☐		
If the Patient is a minor (under the age of 18) please provide information for the parent/legal guardian. Parent/Legal Guardian Name: _____ Date of Birth: _____ Gender: M F Social Security #: - - Preferred phone #: () - ☐ Parent ☐ Legal Guardian					
Insurance Information: Primary Medical Insurance: _____ Secondary Medical Insurance: _____ Dental Insurance: _____					
Billing Information: Person responsible for the bill: _____ Relationship: _____ Social Security #: - - Preferred Phone Number: () - Billing address (if different): _____					
Emergency Contact: Relative or friend not living with you that we may contact in case of emergency: Name: _____ Relationship: _____ Phone: () _____					
Treatment, Assignment & Release: I hereby request and authorize Glacier CHC and its providers to treat me for health problems or conditions identified in the course of assessment and evaluation. I also hereby authorize direct payment of benefits to be paid directly to the provider. I understand and agree to pay any and all charges that exceed or that are not covered by insurance. I authorize the provider or insurance company to release any medical, dental or incidental information that may be necessary for either medical or dental care or in processing applications for payment benefits for services rendered.					
Patient/Guardian Signature: _____ Date: _____					



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Patient Registration

Medical History

Name:	Date of Birth:	Today's Date:				
Medicines you are taking (prescription AND non-prescription): ☐ None						
Pharmacy:						
Allergies/Intolerances (list the allergy and the reaction you have to each):						
Surgeries (include date and where each was done):						
Other providers: Do you see other health care providers for any conditions? ☐ Yes ☐ No If yes, please list them and the reason you see each:						
Illnesses: Please check beside the illness(es) that you or members of your family have had. Please include parents, siblings, grandparents, uncles and aunts. *** F = father's side; M = mother's side						
You	F	M	You	F	M	
						Alcoholism
						Hemorrhoids
						Anemia
						Hepatitis or Liver Disease
						Arthritis
						Hernia
						Asthma
						High Blood Pressure
						Bleeding Disorder
						Kidney or Bladder problems
						Cancer
						Low Blood Pressure
						Chronic Bowel/Intestine disease
						Mental Illness, Nervous Breakdown
						Lung Disease (such as COPD)
						Ulcer
						Diabetes
						Pneumonia or bronchitis
						Drug Abuse
						Rheumatic Fever
						Depression
						Sleep Apnea
						Eczema, Hives, Rashes
						Stroke
						Epilepsy/Seizures
						Suicide Attempt
						Eye problems/Glaucoma
						Thyroid Disease
						GERD, Acid Reflux
						Tuberculosis
						HIV/AIDS
						Sexually Transmitted Infection
						Headaches
						Whooping Cough
						Heart Attack
						Croup, RSV, Influenza
						Heart Failure
						Menstrual (Period) Problems
						Heart Arrhythmia
						Other

Screenings with date done and where: Mammography_____ Pap_____ Colonoscopy_____

Patient/Guardian Signature: _____ **Date:** _____



GLACIER COMMUNITY HEALTH CENTER

Patient Registration

SOCIAL HISTORY

"You" on this page refers to the patient, not the parent/guardian.

If the patient is under the age of 12, fill out only highlighted section.

Name:	Date of Birth:	Today's Date:
Do you use tobacco? No ☐ Yes ☐ If yes, cigarettes ☐ chew ☐ Vape ☐ How much and how often		
Have you had sex in the last 12 months? No ☐ Yes ☐ If yes, with: __ men __ women Did you use protection? No Yes		
Do you want to talk about family planning or contraception during your visit today? No ☐ Yes ☐		
When was your last dental cleaning and at what dental clinic?		
Do you have any hearing issues? No ☐ Yes ☐ Do you have vision problems? No ☐ Yes ☐ If yes, what		
Do you get regular exercise? No ☐ Yes ☐ If yes, How often? _____ minutes _____ days per week		
Do you have reliable transportation? No ☐ Yes ☐		
Do you use caffeine? No ☐ Yes ☐ If yes, pop / coffee / energy drinks How many servings/day?		
What kind of diet do you have (examples no red meat, gluten free)?		
Do you feel physically and emotionally safe where you currently live?		
Do you believe you have been the victim of abuse, neglect or assault? No ☐ Yes ☐ If yes, which?		
Do you have emotional barriers such as anxiety or depression? No ☐ Yes ☐ If yes, what?		
Do you have pets? No ☐ Yes ☐ If yes, what kind(s)?		
Do you have a smoke detector in your home? No ☐ Yes ☐		
What do you do for work?		Any hazards at your work?
What is the highest level of education you completed?		
How do you learn best? (Check all that apply) Reading ☐ seeing drawings ☐ hearing it ☐ hands on ☐		
Do you have any religious beliefs? No ☐ Yes ☐ If yes, what?		
What country are you from?		Have you traveled outside the US in the last year, if so where?
Have you been in a Jail/Prison/Detention Center in the last year? No ☐ Yes ☐		
Do you have an advance directive or living will? No ☐ Yes ☐ If yes, please provide a copy to receptionist.		

Patient/Guardian Signature: _____ Date: _____



Glacier Community Health Center and Glacier Dental Clinic are federally funded government programs. This allows us to provide healthcare services to individuals regardless of their ability to pay. Because we receive federal grants, we are required to gather information on household size and income for the patients we serve.

Please note: Your personal information is confidential. It is not disclosed to anyone and is only used to develop statistics regarding our use of federal funds.

In what level does your family income fall (1 – 4)?

Find your family size on the left column, then follow that row to your amount of family income; circle that column.

PLEASE CIRCLE 1, 2, 3, OR 4 FOR INCOME OF HOUSEHOLD.

Federal Schedule of Income 2025

Family Size		1		2		3		4	
		From	To	From	To	From	To	From	To
1	Yr	\$0	\$15,650	\$15,651	\$23,475	\$23,476	\$31,300	\$31,301	and over
2	Yr	\$0	\$21,150	\$21,151	\$31,725	\$31,726	\$42,300	\$42,301	and over
3	Yr	\$0	\$26,650	\$26,651	\$39,975	\$39,976	\$53,300	\$53,301	and over
4	Yr	\$0	\$32,150	\$32,151	\$48,225	\$48,226	\$64,300	\$64,301	and over
5	Yr	\$0	\$37,650	\$37,651	\$56,475	\$56,476	\$75,300	\$75,301	and over
6	Yr	\$0	\$43,150	\$43,151	\$64,725	\$64,726	\$86,300	\$86,301	and over
7	Yr	\$0	\$48,650	\$48,651	\$72,975	\$72,976	\$97,300	\$97,301	and over
8	Yr	\$0	\$54,150	\$54,151	\$81,225	\$81,226	\$108,300	\$108,301	and over

For family units of more than 8 members, add \$5,500 for each additional member.

If you circled columns 1, 2, or 3, you may be eligible for our sliding fee discount program. You can get between 20% and 100% off your health care bill, with only a \$25 co-pay per visit. The next step is to complete the Financial Worksheet and provide the necessary proof of income.

Please Select Option and Sign Below:

_____ Yes, I'm interested in applying for sliding fee.

_____ No, I'm not interested in applying for sliding fee.

I realize that if I do not qualify for the sliding fee discount or choose not to apply for it, I will be responsible for making full payment. I know that I may apply for the sliding fee discount at any time I receive service.

Patient Signature: _____

Date: _____

Acknowledgement

Notice of Privacy Practices for Patients

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Medical Records Department. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

We need you to be fully informed and actively involved in your care.

By my signature below I acknowledge receipt of the Notice of Privacy Practices for Patients form.

Signature of patient, client or authorized representative

Date

Printed name if signed on behalf of patient or client

Relationship (parent, legal guardian, personal representative, etc.)

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

Date:	Initials:	Reason:
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Effective Date: 01-02-04, revised 05/22/18



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1) Little interest or pleasure in doing things:	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless:	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much:	☐	☐	☐	☐
4) Feeling tired or having little energy:	☐	☐	☐	☐
5) Poor appetite or overeating:	☐	☐	☐	☐
6) Feeling bad about yourself – or that you are a failure or have let yourself or your family down:	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television:	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed. Or the opposite? being so fidgety or restless that you have been moving around a lot more than usual:	☐	☐	☐	☐
9) Thoughts that you would be better off dead, or of hurting yourself in some way:	☐	☐	☐	☐

Total Score:



GLACIER
Community Health Center

519 E. Main St., Cut Bank, MT 59427
(406) 873-5670 (ph) (406) 873-5675 (fax)
www.glacierchc.org

SBIRT SCREENING

Patient Name: _____ Date: _____

ALCOHOL USE

- 1) How often do you have a drink containing alcohol? ☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week
- 2) How many drinks containing alcohol do you have on a typical day when you are drinking? ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 or 9 ☐ 10 or more
- 3) How often do you have five or more drinks on one occasion? ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

DRUG USE

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

☐ 0 ☐ 1 or more

GENERALIZED ANXIETY DISORDER SCALE (GAD-7)

Patient Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1) Feeling nervous, anxious, or on edge	☐	☐	☐	☐
2) Not being able to stop or control worrying:	☐	☐	☐	☐
3) Worrying too much about different things:	☐	☐	☐	☐
4) Trouble relaxing:	☐	☐	☐	☐
5) Being so restless that it is hard to sit still:	☐	☐	☐	☐
6) Becoming easily annoyed or irritable:	☐	☐	☐	☐
7) Feeling afraid as if something awful might happen:	☐	☐	☐	☐

Total Score:

If you check any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

___ Not difficult at all ___ Somewhat difficult ___ Very difficult ___ Extremely difficult

Interpretation of Total

___ (5-9) Mild
___ (10-14) Moderate
___ (15 and over) Severe



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Tobacco Use (Standard)

Patient Name: _____ Date: _____

Please answer according to your personal tobacco use:

Tobacco Use:

- ☐ Nonsmoker
- ☐ Current Smoker
- ☐ Chew Tobacco
- ☐ E-Cigarette (Vaping)

When did you start using tobacco? _____

How soon after you wake up do you use tobacco?

- ☐ Within 5 minutes
- ☐ 6-30 minutes
- ☐ 31-60 minutes
- ☐ 60+ minutes

Frequency of Use:

- ☐ Only Some Days
- ☐ Light Use (1/4 pack/day)
- ☐ Moderate Use (1/2 pack/day)
- ☐ Heavy Use (1 pack or more/day)
- ☐ Chew Tobacco Daily

Are you interested in quitting?

- ☐ Yes
- ☐ No

imMTrax Consent Form for Adults



imMTrax Consent Form for Adults

Name: _____ Sex: M ___ F ___ Date of Birth: _____

I authorize my health care provider and a public health agency to collect and enter my immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my medical care and treatment. In addition, information may be released to schools in order to comply with immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

Signature: _____

Date: _____



Glacier Community Health Center- Dental Clinic Appointment Agreement

It is important for patients to keep their appointments, because broken appointments result in lost time that could have been used to treat other patients.

Rescheduling Appointments

We understand that sometimes situations arise that require rescheduling of your appointment. If you need to reschedule, please call the dental clinic 24 hours before the appointment time.

Broken Appointments

If you miss a scheduled appointment or cancel, it less than twenty-four hours prior, a broken appointment will be recorded in your chart. *If you are 5 minutes late from your designated arrival time, a broken appointment will also be recorded,* and you may have to be rescheduled if there is not enough time to complete your visit. It is not fair to keep other patients waiting because someone showed up late.

If you miss a scheduled dental appointment, all subsequent scheduled dental appointments will be cancelled.

If you have three broken appointments during the past six months, you will not be able to make a regular appointment for a period of six months from the date of the third broken appointment. If you require medical, dental or mental health services during those six months, you may come and wait for an open appointment.

I understand this Appointment Agreement and agree to follow the terms of the broken appointment policy.

Patient Name (please print)

Date

Patient or Guardian Signature

If you would like a full copy of the appointment agreement, please request one from the receptionist.



GCHC Dental Tooth Questionnaire

Patient Name _____

Date _____

When was your **last** dental visit? _____

Are you aware of clenching or grinding your teeth while awake or asleep?

- Yes
- No

Have you ever been treated for TMJ problems?

- Yes
- No

Have you ever had orthodontic treatment?

- Yes
- No

Have you ever been told you need orthodontic treatment?

- Yes
- No

Have you ever been told that you need medication prior to dental procedures?

- Yes
- No

Do you brush your teeth?

- Yes *How often?* _____
- No

Do you floss your teeth?

- Yes *How Often?* _____
- No

Do you use fluoride toothpaste?

- Yes
- No

Do you eat mostly at meal times? (breakfast, lunch, dinner) and/or do you snack?

How often do you drink soda, energy drinks, Gatorade, or juice?

Health Leads Screening Tool

The following set of questions is designed to help us understand if you are facing any challenges in your daily life that may affect your health. All information you share is kept private and is only used to help you access necessary support

Name: _____

Date: _____

		Yes / No
	Within the past 12 months, have you worried whether food would run out before you got money to buy more?	Y N
	In the last 12 months, has the electric, gas, or water company threatened to shut off your services in your home?	Y N
	Do you think you are at risk of becoming homeless?	Y N
	Do problems getting child care make it difficult for you to work or study? (leave blank if you do not have children)	Y N
	Sometimes people find that their income does not quite cover their living costs. In the last 12 months, has this happened to you?	Y N
	In the past 12 months, has a lack of transportation kept you from medical appointments, work, or getting things for daily living? Circle all that apply: Medical appts, work, daily living	Y N
	I often feel that I lack companionship.	Y N
	Do you need help finding a job and/or job training program?	Y N
	Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight	Y N
	If you checked YES to any boxes above, would you like to receive assistance with any of these needs? Phone #: _____ Best time to call: _____	Y N

☐

I'm not interested in any services right now.

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Release of Information

Authorization to access the records of:

Name Last	First	Middle	Date of Birth
Patient ID Number	SS# / Other ID Number	Former names	Location of Service

Request information FROM / TO (please circle one):

Organization or Affiliation	Glacier Community Health Center, Inc.
Phone Number	(406) 873-5670
Fax Number	(406) 873-5675
Address	519 E Main St
City	Cut Bank
State	MT
ZIP Code	59427

Information FROM / TO (please circle one):

Facility or Person's Name <u>(1)</u>	Phone Number	Fax Number
Address	City	State
ZIP Code		
Reason For Release		
Facility or Person's Name <u>(2)</u>	Phone Number	Fax Number
Address	City	State
ZIP Code		
Reason For Release		

Authorization For Release:

I authorize the following release of information from my records. I understand that information may be provided orally, by mail, fax, or hand delivery. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility benefits.

Check all that apply: (If only wanting specific people/clinics access to certain records, write number next to box)	Records From Date
☐ Medical Record	Records To Date
☐ Progress and Treatment Notes	
☐ X-Ray and/or Imaging Reports	
☐ Laboratory / Pathology Results	
☐ Other	
☐ HIV/AIDS and STD Test Results, diagnosis or treatment records MCA 50-16-1000	
☐ Genetic Testing Information	
☐ Behavioral Health Records	
☐ Chemical Dependency (CD) Records (42 CFR Part 2)	

I understand that all healthcare information, whether generated by you or by any other source may be released to me or to the designated person(s) or facilities above for the purpose given. I may revoke this release in writing at any time, but I understand that revocation will not affect any information that was already released. A copy of this form is valid to give my permission to release records. MCA 50-16-531 GCHC may charge to provide copies of its records. MCA 50-16-816

Authorization to Give and Receive Information Regarding Healthcare (Appointment Scheduling Only)

I give permission to (re)schedule/cancel the following types of appointments to the person(s) listed below:

* This authorization ONLY gives permission for appointments unless specified above ↑

☐ Medical
 ☐ Behavioral Health
 ☐ Dental
 ☐ P2ATCH (Palliative)
 ☐ Other _____

Names: _____

Print Name	Date Signed	Phone Number (Including Area Code)
Authorized By (Signature):	Date to Expire:	
If none written, authorization will not expire unless revoked		
If I am not the person whose records are being released, I am authorized to sign because I am the: ☐ Parent ☐ Legal Guardian (Attach copy of court order) ☐ Other (Specify) _____		

To those receiving information under this authorization: Federal and state laws and regulations protect the information disclosed to you. You may not release it to any other person or entity without specific written consent. You are subject to the same standards and laws of confidentiality as the originating holder of the records.