**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**:_____

**GLACIER COMMUNITY HEALTH CENTER**

**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**:_____

Updated 09/24/2024

GLACIER
Community Health Center

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:_____

**Glacier Community Health Center**
**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 clinic as soon as you know that you will not be able to keep the appointment, preferably at least 24 hours before the appointment time.

## Broken Appointments

*If you miss a scheduled appointment or cancel it less than two hours prior, a broken appointment will be recorded in your chart.* If you are 15 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 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

# *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:** |
|---|---|---|
| | | |

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