



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? <input type="checkbox"/> Yes <input type="checkbox"/> No			Cell phone: () - OK to leave message? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____			Work Phone: () -		
Employer: _____			OK to leave message: Yes <input type="checkbox"/> No <input type="checkbox"/>		
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 #: () -					
<input type="checkbox"/> Parent <input type="checkbox"/> 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):		<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> If yes, cigarettes <input type="checkbox"/> chew <input type="checkbox"/> Vape <input type="checkbox"/> How much and how often		
Have you had sex in the last 12 months? No <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/>		
When was your last dental cleaning and at what dental clinic?		
Do you have any hearing issues? No <input type="checkbox"/> Yes <input type="checkbox"/> Do you have vision problems? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, what		
Do you get regular exercise? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, How often? _____ minutes _____ days per week		
Do you have reliable transportation? No <input type="checkbox"/> Yes <input type="checkbox"/>		
Do you use caffeine? No <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> If yes, which?		
Do you have emotional barriers such as anxiety or depression? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, what?		
Do you have pets? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, what kind(s)?		
Do you have a smoke detector in your home? No <input type="checkbox"/> Yes <input type="checkbox"/>		
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 <input type="checkbox"/> seeing drawings <input type="checkbox"/> hearing it <input type="checkbox"/> hands on <input type="checkbox"/>		
Do you have any religious beliefs? No <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/>		
Do you have an advance directive or living will? No <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

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? <i>(leave blank if you do not have children)</i>	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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GLACIER
Community Health Center

**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

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: _____



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



GLACIER
Community Health Center

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

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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Feeling down, depressed, or hopeless:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Trouble falling or staying asleep, or sleeping too much:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Feeling tired or having little energy:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Poor appetite or overeating:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Feeling bad about yourself – or that you are a failure or have let yourself or your family down:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Trouble concentrating on things, such as reading the newspaper or watching television:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) Thoughts that you would be better off dead, or of hurting yourself in some way:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score:



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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



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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Not being able to stop or control worrying:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Worrying too much about different things:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Trouble relaxing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Being so restless that it is hard to sit still:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Becoming easily annoyed or irritable:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Feeling afraid as if something awful might happen:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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