

## **PRE-APPOINTMENT FORMS CHECK LIST**

**Welcome to Nasson Health Care!** In order to facilitate the registration process, and to save you time on the day of your appointment, we ask that you bring in or mail **all the completed forms** listed below.

**Please mail or bring with you to: Nasson Health Care**  
PO Box 72, Sanford, ME 04073

**When you come in for your first appointment, please bring all current medication bottles with you.**

**Pages 2 & 3 REGISTRATION FORM**  
Please fill out completely and remember to sign it.

**Pages 4 & 5 HEALTH HISTORY QUESTIONNAIRE**  
Please fill out both front and back of the form.

**Page 6 HOUSEHOLD DATA**  
When filling out this form, income needs to be included; this is confidential and does not affect sliding fee scale determination. This form needs to be filled out completely so we can continue to fulfill our grant requirements.

**Please read the forms carefully. If you should have any questions, please don't hesitate to call us at (207) 490-6900.**

Our goal is to exceed your expectations each time you visit our office. In order to provide an efficient, productive patient experience, we prepare and review as much information as possible prior to your arrival.

Thank you!

**REGISTRATION FORM**

Please Print

Today's Date \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

**Notification Preferences**

Check all that apply

- Email
- Phone Call
- Portal
- SMS Text
- Voice Mail

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  Sr.  Jr.

Previous Name (s) \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Patient's Social Security Number \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

PO Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email address \_\_\_\_\_ Mother's maiden name \_\_\_\_\_

Marital Status (Check one)  Single  Married  Divorced  Separated  Widowed  Partnered

Current Employer Name \_\_\_\_\_ Employer Phone Number \_\_\_\_\_

Employer Address \_\_\_\_\_

Parent name (if minor patient) \_\_\_\_\_  Legal Parent/Guardian  Foster Parent  Other \_\_\_\_\_

Parent/Legal Guardian/Foster Parent Date of Birth \_\_\_/\_\_\_/\_\_\_

**HEALTH INSURANCE**

Yes  No Please provide all copies of your insurance cards (you may also text copies of the front and back of your card(s) to 207-490-6900)

Insurance Type  Maine Care  Medicare A  Medicare B  Commercial  Other \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_

Policy Holder SS# \_\_\_\_\_ Relationship to policy holder \_\_\_\_\_

Name of Insurance \_\_\_\_\_ Insurance ID# \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insurance \_\_\_\_\_ Insurance ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Claims Address (on the back of the insurance card)  
\_\_\_\_\_

**PHARMACY 1**

Name	Town
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**PHARMACY 2**

Name	Town
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Please continue on other side.

**PERMISSION TO RELEASE HEALTH INFORMATION**

I give **permission to release health information** regarding my treatment received at this facility to the below listed person(s)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone number \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone number \_\_\_\_\_

None – I choose not to list anyone on my permission to share.

**EMERGENCY CONTACT / SUPPORT ROLE**

Please notify person listed below	Relationship to patient	Home phone No.	Home, Cell or Work phone

**NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have the right to access Nasson Health Care’s notice of privacy practices. I understand that I may request a paper copy, or view them on Nasson Health Care’s website. [www.nassonhealthcare.org](http://www.nassonhealthcare.org)

**CONSENT**

- I am personally responsible for providing accurate and current insurance information.
- I authorize my insurance benefits to be paid directly to the physician at York County Community Action Corporation / Nasson Health Care
- I authorize release of all information necessary to secure payments of benefits.
- I understand that I am financially responsible for any remaining balance.
- I consent for medical images to be made of me (photo, video and/or audio) to be used in my medical record, and/or for diagnosis and treatment purposes. Refusal to consent will in no way affect the medical care I receive.
- I am aware of Maine’s Minor’s Rights to Confidential Health Care as how it pertains to mental health, substance abuse, and reproductive health services. A copy of this law will be mailed to me upon my request.
- I understand that signing this form permits my child to receive all services provided by Nasson Health Care. These services include diagnosis and treatment of acute illnesses, mental health services, and reproductive health services.

I certify that the above information is true and correct to the best of my knowledge.

\_\_\_\_\_  
Patient, Parent or Guardian Signature

Date: \_\_\_\_\_

Guardian Documentation Received  Yes  No

# HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):	<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:
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Primary Care Provider	Date of last physical exam
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## PERSONAL HEALTH HISTORY

**List any medical problems that have been diagnosed, surgeries and hospitalizations**


Have you been tested for TB in the past 6 months?  Yes  No      If yes, were results positive or negative?

**FEMALES:** Are you pregnant or trying to get pregnant?  Yes  No      Are you breast feeding?  Yes  No  
 Are you taking oral contraceptives  Yes  No

<b>TOBACCO</b>	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – packs per day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day
	<input type="checkbox"/> Vape – #/day	<input type="checkbox"/> Number of years	
<b>Substance Abuse</b>	Do you have a history of substance abuse or do you currently have a substance abuse problem? (Drugs, alcohol, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Personal Safety</b>	Have you ever been verbally, sexually, or physically hurt by anyone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you currently feel safe in your environment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## ALLERGIES: Including Acrylic, Metal, Latex and Local Anesthetics

Name the source:	Reaction:

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

### MEDICATIONS

Preferred Pharmacy:		
Name of Medication:	Strength:	Frequency taken:

### FILL OUT THIS SECTION ONLY IF YOU WILL BE ESTABLISHING WITH A BEHAVIORAL HEALTH PROVIDER OR A DENTAL PROVIDER

#### FOR BEHAVIORAL HEALTH CARE MENTAL HEALTH HISTORY

Please list mental health providers you have seen in the last five (5) years		
Provider Name	How long you were seen	Reason you were seen

#### FOR DENTAL HEALTH CARE DENTAL HEALTH HISTORY

Do you have a current problem? (pain, swelling, sensitivity, broken tooth etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please describe:	
When was your last dental visit?	Dentist's Name:
What type of treatment was performed?	

## HOUSEHOLD & PERSONAL INFORMATION

The information in your medical record is confidential and is protected under Maine Revised Statutes Title 22, Section 1711-C. Your written consent will be required for release of information except in the case of a court order.

Nasson Health Care relies on federal funding to make our services available to everyone. Your answers to these questions help us continue to receive that funding. Thank you.

**LEGAL NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PREVIOUS NAME(S)** \_\_\_\_\_

**Do you speak English?**     Yes     No    If no, what language do you speak? \_\_\_\_\_

- Race:**
- |  |                                       |                                     |  |
|--|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> Chinese      | <input type="checkbox"/> Filipino   | <input type="checkbox"/> Guamanian                         |
| <input type="checkbox"/> Black/ African American       | <input type="checkbox"/> Asian        | <input type="checkbox"/> Japanese   | <input type="checkbox"/> Chamorro                          |
| <input type="checkbox"/> Native Hawaiian               | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Korean     | <input type="checkbox"/> Samoan                            |
| <input type="checkbox"/> White                         | <input type="checkbox"/> Other Asian  | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> More than one race                |
|  |                                       |                                     | <input type="checkbox"/> Unreported/Refused to report race |

- Ethnicity:**
- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Decline to Specify |
| <input type="checkbox"/> Mexican                | <input type="checkbox"/> Mexican American   | <input type="checkbox"/> Other              |
| <input type="checkbox"/> Chicano/a              | <input type="checkbox"/> Puerto Rican       | <input type="checkbox"/> Unknown            |
| <input type="checkbox"/> Cuban                  |   |   |

**Are you a migrant worker or seasonal farm worker?**     Yes     No

**Are you a Veteran?**     Yes     No

- |  |  |  |   |
|--|--|--|---|
| <p><b>Birth Sex</b></p> <input type="checkbox"/> Male<br><input type="checkbox"/> Female | <p><b>Gender Identity</b></p> <input type="checkbox"/> Male<br><input type="checkbox"/> Female<br><input type="checkbox"/> Female to Male - Transgender<br><input type="checkbox"/> Male to Female – Transgender<br><input type="checkbox"/> Genderqueer, neither exclusively male nor female<br><input type="checkbox"/> Other _____<br><input type="checkbox"/> Choose not to disclose | <p><b>Sexual Orientation</b></p> <input type="checkbox"/> Straight – not lesbian or gay<br><input type="checkbox"/> Lesbian or gay<br><input type="checkbox"/> Bisexual<br><input type="checkbox"/> Something else<br><input type="checkbox"/> Don't know<br><input type="checkbox"/> Choose not to disclose | <p><b>Preferred Pronoun</b></p> <input type="checkbox"/> He, Him, His<br><input type="checkbox"/> She, Her, Hers<br><input type="checkbox"/> They, Them, Theirs<br><input type="checkbox"/> Ze, Hir<br><input type="checkbox"/> Other<br><input type="checkbox"/> Decline to answer<br><input type="checkbox"/> Asked but unknown |
|--|--|--|---|

- Housing Status:**
- Rent:     Yes     No    Public Housing     Yes     No    Is rent based on income?     Yes     No
- Own Home:     Yes     No
- Homeless Shelter:     Yes     No
- Transitional Housing:     Yes     No
- Doubling Up:     Yes     No
- Other: \_\_\_\_\_

**Household:**    List the people who live with you (List additional people on back of form)

Last Name	First Name	Date of Birth	Relationship to you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Confidential Household Income:** (You plus spouse.)  
 \$ \_\_\_\_\_    Check one:     Weekly     Monthly     Yearly