LITTLE RIVERS HEALTH CARE

Little Rivers Health Care, Inc. – A Federally Qualified Health Center
Please check at which clinic you are registering.

- ☐ **Bradford Clinic**
- ☐ **East Corinth Clinic**
- ☐ **Newbury Clinic**
- ☐ **Wells River Clinic**

Patient Information:

Name: (First) _____(Middle)_____(Last)_____DOB:_____
Previous Name(s): _____ Social Security Number _____
Mailing Address: _____
Physical Address if different from above: _____
Home Phone: (_____) _____ Cell Phone: (_____) _____Work Phone: (_____) _____

Would you like access to our online Patient Portal? *

☐ No ☐ Yes, email required _____

***** *Vermont has strict guidelines regarding portal access. LRHC needs a written release from the patient over the age of 12 to allow others (parent or guardian) to access the portal. Please ask front desk member for the form.*

How would you like us to remind you of appointments?

- ☐ Phone call (preferred #)_____
- ☐ Text message
- ☐ Email (Please make sure email is listed above)

If unable to reach me:

- ☐ LRHC may leave extended message.
  (Medical and appointment information)
  or
- ☐ LRHC may leave a brief message for return call

Pharmacy Information: Local Pharmacy Name/ Location:_____
Mail Order Pharmacy Name (if applicable): _____

Primary Insurance Information:

Insurance_____Subscriber_____
Group # _____ ID #_____ Effective Date:_____
Relationship to patient: ☐Self ☐Spouse ☐Parent ☐ Other (specify)_____
Are you employed? ☐ Yes ☐ No

Secondary Insurance Information:

Insurance_____Subscriber_____
Relationship to patient: ☐Self ☐Spouse ☐Parent ☐ Other (specify)_____
Group # _____ ID #_____ Effective Date:_____

Responsible Party Information (Who is Responsible for Paying the Bill) – COMPLETE ONLY IF NOT SAME AS PATIENT:

Last Name_____First Name_____Middle Name _____
Address_____City_____State_____Zip _____
DOB _____ Relationship to Patient:_____
Home Phone: (____)_____Work Phone: (____)_____Cell Phone: (____)_____

As a Federally Qualified Health Center, we are required to collect the following information.
We realize this is very personal information but our federal funding is affected by our ability to capture this information.
Please know that your responses will be strictly confidential.

Marital Status:

☐Married ☐Single ☐Divorced
☐Partner ☐Widowed
☐ Legally Separated

Do you have an Advanced Directive?

☐Yes ☐No

Primary Language Spoken:

☐English ☐Spanish
☐Other _____

Will you Need Interpreter Services?

☐Yes ☐No

Race:

☐ White ☐Black/African American
☐ Native Hawaiian ☐Other Pacific Islander
☐ American Indian/Alaskan Native ☐Asian
☐ Vietnamese ☐Asian Indian ☐Other Asian
☐ Chinese ☐Filipino ☐ Japanese
☐ Korean ☐ Guamanian or Chamorro
☐ Samoan ☐More than on race
☐ Other/Choose not to report

Ethnicity:

☐ Not Hispanic, Latino/a, or Spanish Origin
☐ Another Hispanic, Latino/a, or Spanish Origin ☐ Cuban ☐Puerto Rican
☐ Mexican, Mexican American, Chicano/a

Are you a United States Veteran or on Active duty?

Veteran ☐Yes ☐ No

Are you homeless?

☐Yes ☐ No ☐Choose not to answer

Are you a migrant worker?

☐Yes ☐No

Are you a seasonal worker?

☐Yes ☐No

Gender Identity:

☐ Male ☐Female
☐Transgender- Male (Female-To-Male)
☐Transgender Female (Male-To-Female)
☐Genderqueer
☐Something else, please describe _____
☐Choose Not to Disclose

Do you think of yourself as (check one):

☐Lesbian/Gay/Homosexual
☐Straight/heterosexual ☐Bisexual
☐Something Else ☐Don't know
☐Choose Not to Disclose Legal

Assigned Sex at Birth:

What sex were you assigned at birth on your original birth certificate (While LRHC recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence. If your preferred name and pronouns are different from these, please let us know)

☐Male ☐ Female ☐ Declined to answer

Preferred Pronouns _____

Release of Your Protected Health Information

Little Rivers Health Care is authorized to disclose protected health information as directed below: Please check specific information that is released for each contact listed. ***This authorization shall be in effect until revoked by the patient or authorized representative. If you are the parent/guardian, you must fill in your information below for our office to release information to you.***

Parent/Guardian – Release information to the following person. Additional contacts on page 3. Check all that apply for what purpose(s):

Name: _____ Relationship _____ Phone (____)_____
____ HIPPA contact- LRHC may release all information to the person listed above Phone (____)_____
____Emergency contact

Parent/Guardian – Release information to the following person. Additional contacts on page 3. Check all that apply for what purpose(s):

Name: _____ Relationship _____ Phone (____)_____
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____Emergency contact

_____	_____	_____
Signature of Patient/Legal Representative	Printed Name of Patient/Representative	Date